

95 06501

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA B. BEHLERT				2. DATE OF DEATH MONTH DAY YEAR MARCH 1, 1995		3. TIME OF DEATH 6:35 P M	
4. SOCIAL SECURITY NUMBER 216-28-6177		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 21, 1930-	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH N/A			
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lutherville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 140 Greenmeadow Drive		10f. ZIP CODE 21093	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator		16b. KIND OF BUSINESS/INDUSTRY Cab Company	
17. FATHER'S NAME (First, Middle, Last) William Martin Gray				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Virginia Danielak Danielak			
19a. INFORMANT'S NAME (Type/Print) Judith B Cox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Gittings Avenue Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Hill 3/4		20c. LOCATION — City or Town, State Towson, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Renal Failure							
b. Liver Failure							
c. Metastatic endometrial carcinoma							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. D. Rizzo MD.				29c. LICENSE NUMBER D44529		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Douglas Rizzo, 600 N. Wolfe St., Baltimore, MD 21205							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06502

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Melvin Bischoff Sr.				2. DATE OF DEATH MONTH February DAY 28, YEAR 1995		3. TIME OF DEATH 7:30 A M	
4. SOCIAL SECURITY NUMBER 213-07-0945		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 9, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not Institution, give street and number) 3245 Belair Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE Maryland				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3245 Belair Road		10f. ZIP CODE 21213	
10g. CITIZEN OF WHAT COUNTRY? U. S. A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) n/a College (1-4 or 5+) n/a				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder		16b. KIND OF BUSINESS/INDUSTRY Ship Yard	
17. FATHER'S NAME (First, Middle, Last) Charles M. Bischoff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Unknown			
19a. INFORMANT'S NAME (Type/Print) Charles M. Bischoff Jr. (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R-D-3 Box 177A, Glen Rock, Pennsylvania 17327			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 3/1		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Godack, Jr.</i>				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms lane, Baltimore, Md. 21213			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. possible anything DUE TO (OR AS A CONSEQUENCE OF): b. Hx of anterior hemiblock, 2nd degree DUE TO (OR AS A CONSEQUENCE OF): c. possible coronary artery heart block DUE TO (OR AS A CONSEQUENCE OF): d. disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pm							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Victoria Vanik MD				29c. LICENSE NUMBER D 32381		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Victoria Vanik, Brehms Lane Medical Center, 3401 Mannasota Ave., Balto, Md.							
31. DATE FILED (Month, Day, Year) MAR 6 2 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06503

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gerald Thomas Berends				2. DATE OF DEATH MONTH DAY YEAR February 24, 1995				3. TIME OF DEATH 12:43 P. M.	
4. SOCIAL SECURITY NUMBER 220-62-3118		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Dec. 12, 1953				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 4107 Slater Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4107 Slater Avenue				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter				16b. KIND OF BUSINESS/INDUSTRY Contracting Company	
17. FATHER'S NAME (First, Middle, Last) Irwin A. Berends, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth I. Collins					
19a. INFORMANT'S NAME (Type/Print) Ruth I. Berends (mother)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Slater Ave., Baltimore, MD 21236					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 2/27				20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Stanley Felsenberg, 11 E. Chase Street, Baltimore, MD 21202				29c. LICENSE NUMBER D01085		29d. DATE SIGNED (Month, Day, Year) Feb 24, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) Dr. Stanley Felsenberg, 11 E. Chase Street, Baltimore, MD 21202									
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06504

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SADIE ELIZABETH BROCATO				2. DATE OF DEATH MONTH DAY YEAR FEB 28 1995		3. TIME OF DEATH 1:00P M	
4. SOCIAL SECURITY NUMBER 220-05-7874		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 23 1901	
9a. FACILITY NAME (If not institution, give street and number) KNOLLWOOD MANOR CONVALECENT				9b. CITY, TOWN OR LOCATION OF DEATH MILLERSVILLE		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 213 PONTIAC AVE.				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOUSEHOLD			
17. FATHER'S NAME (First, Middle, Last) MICHAEL JAMES LOCKERMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY CLARICE HOPKINS			
19a. INFORMANT'S NAME (Type/Print) MARGARET LANGLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 84 Langley Lane Solomons MD 20688			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MAGOTHY UNITED METH. CEM 3/2/95 PASADENA, MARYLAND		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Henry L. Stallings, Jr.				22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. 3111 MOUNTAIN ROAD PASADENA MARYLAND 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Sepsis c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Infarct Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Attending Doctor				29c. LICENSE NUMBER D 21684		29d. DATE SIGNED (Month, Day, Year) 2-28-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CV. CYRIAC M.D. 1600 CRAWFORD #106, GLENBURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06505

Item: 19b, per F.H. G-721 3/2/95 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES E. BOETTCHER				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1995		3. TIME OF DEATH HOURS MINUTES 8:35 P M	
4. SOCIAL SECURITY NUMBER 217-38-4061		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 6, 1921	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH MARYLAND	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3503 LOCHEARN CT. APT B			
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) CLERICAL		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERICAL		16b. KIND OF BUSINESS/INDUSTRY MONTGOMERY WARDS			
17. FATHER'S NAME (First, Middle, Last) DANIEL WEBSTER TOWNSEND				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSLIE SINCLAIR WATSON			
19a. INFORMANT'S NAME (Type/Print) ROBERT E. BOETTCHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 852 Shelby Blvd. Edgewater, Maryland 21037			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLCREST CEMETERY 3/3/95		20c. LOCATION — City or Town, State ANNAPOLIS, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hilary N. Stallings Jr.</i>				22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive CVA a. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerosis b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1-hour 20 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 104 c. Hemorrhage							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Schwartz</i>				29c. LICENSE NUMBER 60265		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID A. SCHWARTZ M.D. - 300 HOSPITAL DRIVE, #215, GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06506

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Sarah Bell</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>25</u> YEAR <u>95</u>		3. TIME OF DEATH <u>0345A</u> M	
4. SOCIAL SECURITY NUMBER <u>245-42-0596</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>68</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAR. 28, 1926</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>BAYVIEW HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>		9c. COUNTY OF DEATH <u>n/a</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>5410 SEWARD AVENUE</u>				10f. ZIP CODE <u>21206</u>		10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2nd</u> College (1-4 or 5+) <u>-</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>DOMESTIC</u>		16b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>	
17. FATHER'S NAME (First, Middle, Last) <u>JOHN BATTS</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARTHA</u>			
19a. INFORMANT'S NAME (Type/Print) <u>ETHEL HILL</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5410 SEWARD AVENUE, BALTIMORE, MARYLAND 21206</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>KING MEMORIAL PARK 3-1</u>		20c. LOCATION — City or Town, State <u>RANDALLSTOWN, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Annette K. Jones</u>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Congestive heart failure</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>Hypertension</u> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Vascular dementia</u> <u>Atrial fibrillation</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Finucane</u>				29c. LICENSE NUMBER <u>D24334</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/25/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>FINUCANE JHBMC</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 02 1995</u>				32. REGISTRAR'S SIGNATURE <u>Li. Anderson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06507

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN MAY CASSELL				2. DATE OF DEATH MONTH FEBRUARY DAY 27 YEAR 1995		3. TIME OF DEATH 12:30 A M	
4. SOCIAL SECURITY NUMBER 218-74-9246		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-26-1916	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 103 BALTIMORE AVENUE, S.W.				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) DAVID LOWRY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAY EVERHART			
19a. INFORMANT'S NAME (Type/Print) CONNIE M. FOWLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 PROVIDENCE ROAD, ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PK 3/27/95		20c. LOCATION — City or Town, State GLEN BURNIE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. peripheral vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary heart failure							Approximate interval Between Onset and Death 3 hrs 3 mos
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D41339		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMIE HARMY MD 297 PENINSULA FARM RD ANNAPOLIS MD 21412							
31. DATE (Month, Day, Year) MAR 02 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 10b

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Wilhelmina C.K. Cullinan</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>1</i> YEAR <i>95</i>		3. TIME OF DEATH <i>7:30 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216-03-6542</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>92</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12/17/02</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Md</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Meridian, Catonsville</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Catonsville</i>	
10c. CITY, TOWN OR LOCATION <i>Catonsville</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>	
16b. KIND OF BUSINESS/INDUSTRY <i>Construction Co.</i>				17. FATHER'S NAME (First, Middle, Last) <i>Michael E. Cullinan</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Louise Hilbert</i>	
19a. INFORMANT'S NAME (Type/Print) <i>Anna Cullinan</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>404 Wheaton Place, Balto, Md, 21228</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, <i>park</i>) <i>Loudon Park Cemetery</i> <i>3/4</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Phyllis Stank</i>				22. NAME AND ADDRESS OF FACILITY <i>Sterling Ashton Funeral Home</i> <i>736 Edmondson Avenue, Balto, Md. 21228</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Severe malnutrition</i>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <i>Colitis (Chronic Disease)</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Rheumatoid arthritis</i> <i>Arteriosclerotic Cardiovascular Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen J. Jucius MD</i>				29c. LICENSE NUMBER <i>D08780</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/2/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06509

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charles Cunningham</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>24</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:45 P M</i>	
4. SOCIAL SECURITY NUMBER <i>216-62-8221</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <i>39</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>August 31, 1955</i>	
8. BIRTHPLACE (State or Foreign Country) <i>md</i>				9a. FACILITY NAME (If not institution, give street and number) <i>University Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>n/A</i>				10a. STATE <i>MD</i>			
10b. COUNTY <i>n/A</i>				10c. CITY, TOWN OR LOCATION <i>Balto</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2123 Boltmst. apt 1 Rear</i>			
10f. ZIP CODE <i>21217</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Unknown</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Disabled</i>	
17. FATHER'S NAME (First, Middle, Last) <i>John M. Cunningham</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Thelma Foulkes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Thelma Foulkes</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2123 Boltm st. apt 1 Rear Balto, md 21217</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <i>mt. Zion Cemetery 3/1/95</i>		20c. LOCATION — City or Town, State <i>Lansdowne, md</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Fortia Elron</i>	
22. NAME AND ADDRESS OF FACILITY <i>March F. H. West 4300 Wabash Ave</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Asystole</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Sept 23</i> <i>multiple myeloma</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Minh Van Ngo</i>				29c. LICENSE NUMBER <i>P06846</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Minh Van Ngo</i>				31. REGISTRAR'S SIGNATURE <i>Johanna Parker</i>			
32. FILED (Month, Day, Year) <i>MAR 02 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



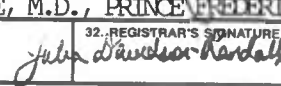
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06510

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN PAUL CURTIN				2. DATE OF DEATH MONTH FEBRUARY DAY 26 YEAR 1995				3. TIME OF DEATH 0010 M	
4. SOCIAL SECURITY NUMBER 037-10-4040		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) MAY 18, 1918	
8. BIRTHPLACE (State or Foreign Country) RHODE ISLAND				9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK	
9c. COUNTY OF DEATH CALVERT				10a. STATE MARYLAND				10b. COUNTY CALVERT	
10c. CITY, TOWN OR LOCATION CHARLOTTE HALL,				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER RT. 2 BOX 5				10f. ZIP CODE 20622				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GENERAL MANAGER/UTILITIES		16b. KIND OF BUSINESS/INDUSTRY CITY OF BRYAN, OHIO					
17. FATHER'S NAME (First, Middle, Last) HENRY FRANCIS CURTIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELLEN MULVEY					
19a. INFORMANT'S NAME (Type/Print) JOHN P. CURTIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT. T-2 1200 WESTERLEE PL., BALT., MD. 21228					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK 3-1-95		OATE		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALT., MD. 21228					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 029657		29d. DATE SIGNED (Month, Day, Year) 2/26/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES A. JUDGE, M.D., PRINCE FREDERICK, MD 20678									
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Leonie C. Chidiac (Affaki)</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 1, 1995</i>				3. TIME OF DEATH <i>2:55pm</i>	
4. SOCIAL SECURITY NUMBER <i>219-37-4595</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 25, 1916</i>				8. BIRTHPLACE (State or Foreign Country) <i>Syria</i>				9c. COUNTY OF DEATH <i>N/A</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Keswick Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Towson</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <i>701 Milldam Road</i>				10f. ZIP CODE <i>21286</i>				10g. CITIZEN OF WHAT COUNTRY? <i>Syria</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 years</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>George Affaki</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Camill Wadia Bally</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Dr. Caesar Shediak</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>701 Milldam Road, Towson, MD 21286</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Dulaney Valley Memorial Gardens 1/3/95</i>				20c. LOCATION — City or Town, State <i>Timonium, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa Joseph Boyd</i>				22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home Inc. 6500 York Road, Baltimore, MD 21212</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic renal failure</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Diabetes mellitus</i>								Approximate Interval Between Onset and Death <i>1 year</i> <i>40 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive arteriosclerotic cardiovascular disease with resultant heart failure</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Isabelle MacGregor MD</i>				29c. LICENSE NUMBER <i>D13657</i>	
29d. DATE SIGNED (Month, Day, Year) <i>March 1, 1995</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. Isabelle MacGregor, Keswick, 700 W. 40th St. Baltimore, MD 21211</i>					
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH V. COLE				2. DATE OF DEATH MONTH 2 DAY 22 YEAR 95		3. TIME OF DEATH 06:45 a.m.	
4. SOCIAL SECURITY NUMBER 220-12-7882		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 21, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview, Geriatric		9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.	
9c. COUNTY OF DEATH None				10a. STATE Maryland			
10b. COUNTY None				10c. CITY, TOWN OR LOCATION Balto. City, Md.			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 43 E. Wheeling St.			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th. Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Webster James, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Hartman			
19a. INFORMANT'S NAME (Type/Print) Ms. Constance M. King				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1741 Clarkson St. Balto. Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park 2/25/95		20c. LOCATION — City or Town, State Elkridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 6 hours	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Possible Pneumonia DUE TO (OR AS A CONSEQUENCE OF):				6 hours	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure, Coronary artery disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ziad Haydar MD</i>				29c. LICENSE NUMBER 043854		29d. DATE SIGNED (Month, Day, Year) 2/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZIAD HAYDAR MD. 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED 3/28/50

95-1074-510

DWG



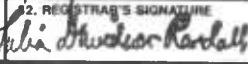
95 06513

ITEMS: 23 PART I, II, 27, PER MEO FILM G-722 4/19/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ALBERT LEE CARPER				2. DATE OF DEATH MONTH FEB. DAY 28 YEAR 95		3. TIME OF DEATH 12:15 P.M.	
4. SOCIAL SECURITY NUMBER 226-44-1696		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 12, 35	
8a. FACILITY NAME (If not institution, give street and number) 1200BLK. PATAPSCO STREET				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8c. COUNTY OF DEATH None	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY None		10c. CITY, TOWN OR LOCATION Balto. City, Md.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1602 Marshall St.				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th. Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sheet Metal		15b. KIND OF BUSINESS/INDUSTRY Maryland Drydock			
17. FATHER'S NAME (First, Middle, Last) Carson J. Carper, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys V. Foley			
19a. INFORMANT'S NAME (Type/Print) Margaret A. Carper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Marshall St. Balto. Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemt. 3/4/95		20c. LOCATION — City or Town, State A.A.Co. Md.		20d. DATE 3/4/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Av			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FATTY LIVER, PULMONARY FIBROSIS							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ON STREET					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MARCH 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06514

ITEMS: 2,29d per F.H. G-721 3/2/95 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ADELAIDE COLLINS				2. DATE OF DEATH MONTH DAY YEAR FEB 27 95		3. TIME OF DEATH 1:00 pm	
4. SOCIAL SECURITY NUMBER 212-58-3709		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) () 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 07, 1904	
9a. FACILITY NAME (If not institution, give street and number) 7700 YORK ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 219 E. LAFAYETTE AVENUE				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: JAMAICIAN		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) -		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUTCHER		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) GEORGE COLLINS				18. MOTHER'S NAME (First, Middle, Maiden Surname) JANE FLEMING			
19a. INFORMANT'S NAME (Type/Print) MARGARET ARNOLD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 RICHWOOD AVENUE, BALTIMORE, MARYLAND 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 3-3		20c. LOCATION — City or Town, State LANSDOWNE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY March F.H. East 1101 E. North Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC UTERINE CANCER Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE c. DUE TO (OR AS A CONSEQUENCE OF): RENAL INSUFFICIENCY d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Raymond A. Wzemba P.A.				29c. LICENSE NUMBER D34184		29d. DATE SIGNED (Month, Day, Year) FEB 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYMOND A WZEMBA 7801, YORK RD #300, TOWSON 21204							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06515

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Graylin Cobbs</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>23</u> YEAR <u>95</u>		3. TIME OF DEATH <u>4:30 P M</u>	
4. SOCIAL SECURITY NUMBER <u>218-58-7944</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>41</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>OCT. 23, 1953</u>	
8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>				9a. FACILITY NAME (If not institution, give street and number) <u>JOHNS HOPKINS</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>BALTIMORE CITY</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>3026 MOSHER STREET</u>	
10f. ZIP CODE <u>21216</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4+</u> College (1-4 or 5+) <u>4+</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>SUBSTANCE ABUSE COUNSELOR</u>		16b. KIND OF BUSINESS/INDUSTRY <u>HEALTH CARE INDUSTRY</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOHN H. COBBS</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARY JONES</u>			
19a. INFORMANT'S NAME (Type/Print) <u>MARY COBBS</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3026 MOSHER STREET, BALTIMORE, MARYLAND 21216</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>ARBUTUS CEMETERY</u>		20c. LOCATION — City or Town, State <u>2-28-95</u> <u>ARBUTUS, MARYLAND</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph H. Brown Jr.</u>	
22. NAME AND ADDRESS OF FACILITY <u>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.</u> <u>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Disseminated Mycobacterium Avium Complex</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Acquired Immunodeficiency Syndrome</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Human Immunodeficiency Virus</u> DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval between Onset and Death <u>1 yr</u> <u>2 yr</u> <u>10 yr</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Candida esophagitis, pancytopenia, chronic diarrhea</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>MD</u>		29c. LICENSE NUMBER <u>57968</u>	
29d. DATE SIGNED (Month, Day, Year) <u>2/26/95</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KIRSI ALLISON MD ID DIV JHH 600 N Wolfe Baltimore MD 21205</u>			
31. DATE FILED (Month, Day, Year) <u>MAR 02 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Campbell, Myrtle L.</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>24</i> YEAR <i>95</i>		3. TIME OF DEATH <i>2003 PM</i>	
4. SOCIAL SECURITY NUMBER <i>243-54-0624</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>59 YRS.</i>		7. DATE OF BIRTH (Month, Day, Year) <i>9/5/35</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MD.</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>869 W. LEXINGTON ST., APT. D</i>			
10f. ZIP CODE <i>21201</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>5TH GRADE</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>OWN HOME</i>	
17. FATHER'S NAME (First, Middle, Last) <i>ABELL NELSON</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>EMMA HUDSON</i>			
19a. INFORMANT'S NAME (Type/Print) <i>EMMA HUDSON</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>869 W. LEXINGTON ST., APT. D, BALTO, MD, 21201</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MT. ZION CEMETERY</i>		20c. LOCATION — City or Town, State <i>3-2-95 BALTIMORE, MARYLAND</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Exsanguination due to multiple injuries</i>							
b. <i>Auto accident</i>							
c. <i>None</i>							
d. <i>None</i>							
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i>2/24/95</i>		28b. TIME OF INJURY <i>6:00 PM</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <i>AUTO ACCIDENT</i>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>STREET</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore, Maryland</i>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER <i>MD D32477</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Brady M. Cushing MD Shock TRAUMA Baltimore</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06517

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK CHARLES DUVALL, JR			2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1995		3. TIME OF DEATH 2:00 AM
4. SOCIAL SECURITY NUMBER 214-22-8478	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12-25-1925		8. BIRTHPLACE (State or Foreign Country) MARYLAND
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION			9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 7686 BRIAR LANE			10f. ZIP CODE 21122	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC		16b. KIND OF BUSINESS/INDUSTRY CURTIS ENGINEER CO.	
17. FATHER'S NAME (First, Middle, Last) FRANK CHARLES DUVALL, SR.			18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE E. FUSS		
19a. INFORMANT'S NAME (Type/Print) MRS. GENE L. GLEESON			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 RIDGELY ROAD, EDGEWATER, MD. 21037		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PK 3/2/95		20c. LOCATION — City or Town, State GLEN BURNIE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061		
23. PART I. Enter the disease(s) or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <i>Metastatic Small Cell Carcinoma of Lung</i> Approximate Interval Between Onset and Death <i>2 days</i> <i>2 mos.</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Russell R. De Luca M.D.</i>			29c. LICENSE NUMBER 031551	29d. DATE SIGNED (Month, Day, Year) February 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RUSSELL R. DE LUCA, M.D./1600 CRAIN HWY, SW #410/GLEN BURNIE, MD 21061					
31. DATE FILED (Month, Day, Year) MAR 02 1995		REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES E. DAVIS				2. DATE OF DEATH MONTH FEBRUARY DAY 27 YEAR 95				3. TIME OF DEATH 8:00 P M	
4. SOCIAL SECURITY NUMBER 217 54 1323		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 101 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) 05 07 93				8. BIRTHPLACE (State or Foreign Country) Lithuania					
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7431 Greenbank Road				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housework				16b. KIND OF BUSINESS/INDUSTRY At Home	
17. FATHER'S NAME (First, Middle, Last) Anthony Burrows				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) William J. Davis Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7431 Greenbank Road Balto., Md. 21220					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 3-2-95				20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → UROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10 days									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Raymundo Shenoy INTERM.				29c. LICENSE NUMBER AS 2441614 -25				29d. DATE SIGNED (Month, Day, Year) FEBRUARY 27-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RAGHUVIR SHENOY M.D. HARBOR HOSPITAL CENTRE - BALTIMORE.									
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE John A. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06519

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Maggie M. Damron</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>20</i> YEAR <i>95</i>		3. TIME OF DEATH <i>11:45 A M</i>	
4. SOCIAL SECURITY NUMBER <i>218-22-5839</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 14, 1910</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>				9. FACILITY NAME (If not institution, give street and number) <i>MERLY MEDICAL CENTER</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE, MD</i>	
9c. COUNTY OF DEATH <i>BALTIMORE CITY</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>None</i>	
10c. CITY, TOWN OR LOCATION <i>Balto. City, Md.</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1035 S. Hanover St.</i>	
10f. ZIP CODE <i>21230</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th. Grade</i> College (14 or 5+) <i>None</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Patient Aid</i>		16b. KIND OF BUSINESS/INDUSTRY <i>City Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>George A. Tinnell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Betty E. Thompson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Harold Lee</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>402 Old Riverside Rd. Balto. Md. 21225</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory Inc. 3/1/95 Catonsville, Md.</i>		20c. LOCATION — City or Town, State		20d. DATE <i>3/1/95</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pulmonary embolus</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Necrotizing Abdominal fascitis</i>							Approximate interval Between Onset and Death <i>1 day.</i> <i>3 days.</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic obstructive pulmonary disease</i> <i>soft tissue infection of abdominal wall</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jason Kaplan MD</i>				29c. LICENSE NUMBER <i>108281</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/20/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mary Hospital 301 St Paul place Baltimore MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06520

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH A. ECKHARDT				2. DATE OF DEATH MONTH DAY YEAR February 28, 1995		3. TIME OF DEATH 3:20 P M	
4. SOCIAL SECURITY NUMBER 212-07-9688		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 29, 1909	
9a. FACILITY NAME (If not Institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY None		10c. CITY, TOWN OR LOCATION Balto. City, Md.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 600 Light St. Apt. 714				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th. Grade College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector		16b. KIND OF BUSINESS/INDUSTRY Koppers Co.	
17. FATHER'S NAME (First, Middle, Last) Unknown Gosnell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Mrs. Eileen R. Right				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Andrews Rd. Glen Burnie, Md. 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery, 3.4.95		DATE 3.4.95		20c. LOCATION — City or Town, State A.A. Co. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel A. Haylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Urinary tract infection DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure, renal failure, Gastrointestinal bleeding							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert A. ...</i> M.D. (House officer)				29c. LICENSE NUMBER A5244161451		29d. DATE SIGNED (Month, Day, Year) February 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ioannis E. Eleftheriadis, Harbor Hospital Center							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06521

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES EDWARD FOSTER				2. DATE OF DEATH MONTH FEB DAY 27 YEAR 95		3. TIME OF DEATH 12:00 PM	
4. SOCIAL SECURITY NUMBER 215-34-8320		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 13, 1939	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1415 Stonewood Road			
10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Processor		16b. KIND OF BUSINESS/INDUSTRY Lever Brothers			
17. FATHER'S NAME (First, Middle, Last) James P. Foster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Mayo			
19a. INFORMANT'S NAME (Type/Print) Velva Foster				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Stonewood Road Baltimore, Maryland 21239			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park Mar 4		20c. LOCATION — City or Town, State Baltimore County, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kellum</i>				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe hypoxemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 24 hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.D. J. J. J. J.</i>				29c. LICENSE NUMBER PO 8242		29d. DATE SIGNED (Month, Day, Year) Feb 27, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUHAMMAD ZAYDAN, M.D. Good SAM HOSP. Baltimore, M.D. 21239							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Radell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06522

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEEBELL FLOYD				2. DATE OF DEATH MONTH 2 DAY 25 YEAR 95		3. TIME OF DEATH 11:30 P M	
4. SOCIAL SECURITY NUMBER 213 34 4128		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 7, 1934	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3529 Virginia Avenue				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Family			
17. FATHER'S NAME (First, Middle, Last) Mark Douglas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Tate			
19a. INFORMANT'S NAME (Type/Print) Shirley McClary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3529 Virginia Avenue Baltimore, Maryland 21215			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Memorial Gardens Mar 4 York, South Carolina		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bouley				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → DEHYDRATION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST SEVERE CONSTIPATION DUE TO (OR AS A CONSEQUENCE OF): CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Alexander MD		29c. LICENSE NUMBER P07731		29d. DATE SIGNED (Month, Day, Year) 2-25-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARBARA ALEXANDER UNIV. OF MD 225 GREENE ST Baltimore MD							
31. DATE FILED (Month, Day, Year) MAR 08 1995		32. REGISTRAR'S SIGNATURE John [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06523

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sally (Sallie) Franklin				2. DATE OF DEATH MONTH DAY YEAR Feb. 28-1995				3. TIME OF DEATH 7:15 A M			
4. SOCIAL SECURITY NUMBER 233-56-8292				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 9, 1898		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Eastpoint Nursing Home						9b. CITY, TOWN OR LOCATION OF DEATH Eastpoint			9c. COUNTY OF DEATH Baltimore		
RESIDENCE OF DECEDENT											
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Eastpoint				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1046 Old North Point Road						10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs College (1-4 or 5+) 				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Joel Rose						18. MOTHER'S NAME (First, Middle, Maiden Surname) Rossey Coleman					
19a. INFORMANT'S NAME (Type/Print) Martha Eder						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7465 Durwood Road, Baltimore, Md. 21222					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory 3-1-95 Beltsville, Md.				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins DD0083						22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dehydration and Malnutrition											
DUE TO (OR AS A CONSEQUENCE OF):											
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
DUE TO (OR AS A CONSEQUENCE OF):											
DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Thrombocytopenia											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Melito M. Torres						29c. LICENSE NUMBER 211150		29d. DATE SIGNED (Month, Day, Year) 2/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MELITO M. TORRES, MD 441 S. 22nd Ave, Balto, MD 21224											
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY LEE GIBSON				2. DATE OF DEATH MONTH FEBRUARY DAY 24 , YEAR 1995		3. TIME OF DEATH 4:10A M	
4. SOCIAL SECURITY NUMBER 213-92-2466		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/01/65	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 957 NORTH HILL ROAD		10f. ZIP CODE 21218	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) MASTER DEGREE College (1-4 or 5+) REALTOR	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REAL ESTATE				16b. KIND OF BUSINESS/INDUSTRY REAL ESTATE		17. FATHER'S NAME (First, Middle, Last) JOE GIBSON	
18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE JEAN HOPE				19a. INFORMANT'S NAME (Type/Print) JOE GIBSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 957 NORTH HILL ROAD BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GAR.		20c. LOCATION — City or Town, State COCKEYSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA							
b. RETROVIRAL INFECTION							
c. RETROVIRAL INFECTION							
d. RETROVIRAL INFECTION							
Approximate interval Between Onset and Death 16 DAYS 10 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John A. McPherson, M.D.				29c. LICENSE NUMBER MD244		29d. DATE SIGNED (Month, Day, Year) 2/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN A. MCPHERSON, M.D. 600 N. WOLFE ST. TOWER 110, BALTIMORE, MD 21287							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT H. GOODE				2. DATE OF DEATH MONTH 02 DAY 27 YEAR 95		3. TIME OF DEATH 7:00 AM	
4. SOCIAL SECURITY NUMBER 217-07-5336		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80-84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1910-14-14	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		10. COUNTY OF DEATH NONE	
11. FACILITY NAME (If not institution, give street and number) 1116 KENWOOD AVENUE				12. RESIDENCE OF DECEDENT			
13. STATE MARYLAND		14. COUNTY NONE		15. CITY, TOWN OR LOCATION BALTIMORE CITY		16. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
17. STREET AND NUMBER 1116 N. KENWOOD AVENUE				18. ZIP CODE 21213		19. CITIZEN OF WHAT COUNTRY? UNITED STATES	
20. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X		23. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH College (1-4 or 5+) NONE		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONGSHOREMAN		26. KIND OF BUSINESS/INDUSTRY SHIPPING			
27. FATHER'S NAME (First, Middle, Last) ROBERT GOODE				28. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE			
29. INFORMANT'S NAME (Type/Print) LILLIAN GOODE				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 N. MONROE STREET BALTO, MD. 21217			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS CEM. OWINGS MILLS, MD.		33. LOCATION — City or Town, State BALTO, MD.		34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i>	
35. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME		36. ADDRESS OF FACILITY 1412 E. PRESTON STREET BALTO, MD. 21213		37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arterial sclerosis vascular disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hypertension Diverthensiosis peptic ulcer disease			
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia Cardiopulmonary arrest				39. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
41. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				42. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
43. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				44. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
45. 28a. DATE OF INJURY (Month, Day, Year)		46. 28b. TIME OF INJURY M		47. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		48. 28d. DESCRIBE HOW INJURY OCCURRED	
49. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				50. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
51. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
52. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending Physician</i>				53. 29c. LICENSE NUMBER D30115		54. 29d. DATE SIGNED (Month, Day, Year) 2/28/95	
55. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thiokpeter 2600 Liberty Hts Ave Baltimore MD 21215							
56. 31. DATE FILED (Month, Day, Year) MAR 02 1995				57. 32. REGISTRAR'S SIGNATURE <i>John Swisher Ricketts</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06526

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE,
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Julianne Love Haney				2. DATE OF DEATH MONTH DAY YEAR April 28 1995				3. TIME OF DEATH HOUR MIN. 6:00 PM			
4. SOCIAL SECURITY NUMBER 212-34-7292		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) APR. 26, 1936		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 6807 Blenheim Road Apt. A.						9b. CITY, TOWN OR LOCATION OF DEATH Rodgers Forge			9c. COUNTY OF DEATH Baltimore County		
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Rodgers Forge				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 6807 Blenheim Road Apt. A						10f. ZIP CODE 21212			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY Auto Parts			
17. FATHER'S NAME (First, Middle, Last) Harvey Love						18. MOTHER'S NAME (First, Middle, Maiden Surname) Loretto Margaret Warwick					
19a. INFORMANT'S NAME (Type/Print) Paul G. Haney						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 Winterberry Road, Edgewood, Maryland 21040					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens MAR. 3				20c. LOCATION — City or Town, State Bel Air, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction Complicated by Coronary Artery Disease Approximate interval Between Onset and Death											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D-07383		29d. DATE SIGNED (Month, Day, Year) 2-28-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell - 408 Harper House - 11111 1st Street NE - Washington, DC 20002											
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1077-510

AAM

ITEMS: 23 PART I, 27, 28a, b, c, d, e, f PER MEO G-722 4/6/95 reb

95 06527

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT E. HOLMES, Jr.				2. DATE OF DEATH MONTH DAY YEAR FEB. 28, 1995		3. TIME OF DEATH 15:44 P M					
4. SOCIAL SECURITY NUMBER 212-60-3970		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 15, 1952		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL ER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A				
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 527 Rossiter Avenue				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10th Grade College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY Private							
17. FATHER'S NAME (First, Middle, Last) Robert Holmes, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Holmes							
19a. INFORMANT'S NAME (Type/Print) William Humphries				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 527 Rossiter Avenue Baltimore, MD 21212							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison Mar 3		20c. LOCATION — City or Town, State Owings Mills, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC INTOXICATION Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ b. _____ c. _____ d. _____								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 2/28/95		28b. TIME OF INJURY 3:03 P.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED UNKNOWN			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE CITY, MD.							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) MARCH 01, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE Julia A. H. H. H.									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) GERADINE Geraldine D. HARRISON				2. DATE OF DEATH MONTH FEB DAY 26 YEAR 95		3. TIME OF DEATH 2:57 A.M.					
4. SOCIAL SECURITY NUMBER 218-58-9080		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 9, 1954		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) 903 NOTTINGHAM ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A				
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 903 Nottingham Rd. Apt 4-A				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School Graduate College (1-4 or 5+) Secretary				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary			16b. KIND OF BUSINESS/INDUSTRY State Of Maryland				
17. FATHER'S NAME (First, Middle, Last) Leon Harrison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Christine Peebles							
19a. INFORMANT'S NAME (Type/Print) Christine Harrison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2514 Molton Way Balt. Md. 21244							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Diamond Grove		DATE 3/4/95		20c. LOCATION — City or Town, State Emporia, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Seizure Disorder Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension Obesity								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Obesity								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Deanna J. Clark MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 28, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John HUNN				2. DATE OF DEATH MONTH DAY YEAR February 27, 1995		3. TIME OF DEATH 10:14 P M	
4. SOCIAL SECURITY NUMBER 220-09-2952		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-31-10	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Sospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11345 Pulaski Highway Lot 40				10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Rigger		15b. KIND OF BUSINESS/INDUSTRY Edgewood Arsenal			
17. FATHER'S NAME (First, Middle, Last) Peter Hunn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Ruth Hunn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11345 Pulaski Highway Lot 40, White Marsh, MD 21162			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 3-1-95		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis S. Kelly</i>				22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Atherosclerotic Cardiovascular Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Stenosis of Aortic Valve replacement</i> <i>Aneurysm, RVD</i>							Approximate Interval Between Onset and Death minutes
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIED (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. ...</i>			
29c. LICENSE NUMBER D33943				29d. DATE SIGNED (Month, Day, Year) 2/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Franklin Square Hospital Center				31. DATE FILED (Month, Day, Year) MAR 02 1995			
32. REGISTRAR'S SIGNATURE <i>John A. ...</i>				33. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06530

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Walter Hom				2. DATE OF DEATH MONTH DAY YEAR February 26, 1995				3. TIME OF DEATH 4:30 A. M	
4. SOCIAL SECURITY NUMBER 218-22-7082		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) March 1, 1928				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2 E. Town Ridge Court				10f. ZIP CODE 21236				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) N/A College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Worker				16b. KIND OF BUSINESS/INDUSTRY Steel Company	
17. FATHER'S NAME (First, Middle, Last) Henry Hom				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Eckert					
19a. INFORMANT'S NAME (Type/Print) Mrs. Helen M. Hom (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) c/o Mrs. Dvorak, 2401 Stoney Brook Rd., Fallston, MD 21047					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 3/1				20c. LOCATION — City or Town, State Timonium, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 16 10 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER 	
29c. LICENSE NUMBER D16960				29d. DATE SIGNED (Month, Day, Year) 2-27-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Franklin E. Chatham, 1012 Old North Point Rd., Baltimore, MD 21224									
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


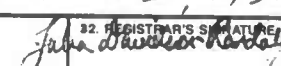
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06531

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH JOHNSTON HOOTON				2. DATE OF DEATH MONTH March DAY 2 YEAR 1995		3. TIME OF DEATH 6:07 a.m.	
4. SOCIAL SECURITY NUMBER 336-18-8064		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 8, 1904	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lutherville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 106 Brightwood Club Drive				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 + 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Architect		16b. KIND OF BUSINESS/INDUSTRY Residential and Commercial			
17. FATHER'S NAME (First, Middle, Last) Joseph Johnston Hooton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Morrison Levy			
19a. INFORMANT'S NAME (Type/Print) Nina H. Gardner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13500 Longnecker Rd., Glyndon, Md. 21071			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Metro Crematory March 3, 1995		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. hypoxia 2° severe pulmonary fibrosis DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 3 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas F. Lansdale M.D.				29c. LICENSE NUMBER D43936		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS F. LANSDALE III, M.D. 6565 N. Charles St, Baltimore, MD 21204							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020



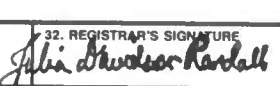
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06532

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RAYMOND E. HEMERICH				2. DATE OF DEATH MONTH DAY YEAR FEB 25 1995		3. TIME OF DEATH 8:32 PM	
4. SOCIAL SECURITY NUMBER 217-38-5287		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 1, 1940	
8a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOC.				8b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		8c. COUNTY OF DEATH MD	
9a. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY ANNE ARUNDEL 10c. CITY, TOWN OR LOCATION PASADENA 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10e. STREET AND NUMBER 1613 CORALIE COURT 10f. ZIP CODE 21122 10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTOM HOUSE BROKER		16b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED			
17. FATHER'S NAME (First, Middle, Last) HARRY E. HEMERICH				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA ZORNAK			
19a. INFORMANT'S NAME (Type/Print) JOAN A. HEMERICH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 CORALIE COURT, PASADENA, MD 21122			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY		20c. LOCATION — City or Town, State 3/1 BROOKLYN PARK, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Steven H. Williams				22. NAME AND ADDRESS OF FACILITY MCCULLY FUNERAL HOME OF PASADENA 3204 MOUNTAIN ROAD, PASADENA, MD 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death 30 min 30 min							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Elevated cholesterol							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D31244		29d. DATE SIGNED (Month, Day, Year) 2-21-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME HASTINGS LAST CARL (first)				2. DATE OF DEATH MONTH 02 DAY 24 YEAR 95		3. TIME OF DEATH 17.30 M	
4. SOCIAL SECURITY NUMBER 189-K6-9610		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 17 1924	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Bayview Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH MD				10a. STATE Maryland			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Dundalk			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8134 Kavanagh Road			
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ironworker		16b. KIND OF BUSINESS/INDUSTRY Local 16 & 5	
17. FATHER'S NAME (First, Middle, Last) Roy Hastings				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Houck			
19a. INFORMANT'S NAME (Type/Print) Margaret C. Hastings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8134 Kavanagh Road Baltimore, Maryland 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. LOCATION - City or Town, State 2/28/1995 Baltimore, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END-STAGE - Type IV congestive heart failure							
b. END-stage Ischemic Cardiomyopathy							
c. 							
d. 							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER K. H. H. H. H. H.				29c. LICENSE NUMBER 95012		29d. DATE SIGNED (Month, Day, Year) 2/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ICULBIR SANDHU - JOHNS HOPKINS BAYVIEW MEDICAL CENTER							
31. DATE FILED (Month, Day, Year) MAR 02 1995				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06534

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TANIEKA HICKSON				2. DATE OF DEATH MONTH FEB DAY 22 YEAR 95		3. TIME OF DEATH 1155 P M	
4. SOCIAL SECURITY NUMBER 217-29-7431		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 4 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 28, 1990	
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH MARYLAND	
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				10e. STREET AND NUMBER 2415 LAURETTA AVENUE		10f. ZIP CODE 21223	
10g. CITIZEN OF WHAT COUNTRY? USA.				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A				16b. KIND OF BUSINESS/INDUSTRY N/A		17. FATHER'S NAME (First, Middle, Last) TYRONE HICKSON	
18. MOTHER'S NAME (First, Middle, Maiden Surname) NATASHA BATES				19a. INFORMANT'S NAME (Type/Print) NATASHA BATES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 LAURETTA AVE., BALTIMORE, MD. 21223	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 3-2-95 CATONSVILLE, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charlene D. Brown				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JKR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Respiratory failure due to Acute Respiratory Distress syndrome caused by fire DUE TO (OR AS A CONSEQUENCE OF): b. Inhalation burn injury due to house fire DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 35% Total body surface area burn	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) M	
28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED HOUSE FIRE	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Mark Buckmaster				29c. LICENSE NUMBER D45327		29d. DATE SIGNED (Month, Day, Year) February 23, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Buckmaster Univ. of Maryland Medical System				31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE Jane Davidson-Randall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

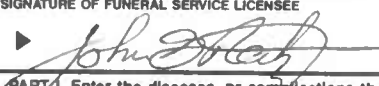

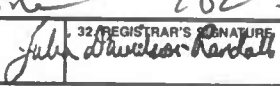
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06535

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN JANNE				2. DATE OF DEATH MONTH DAY YEAR February 27, 1995		3. TIME OF DEATH 9:45 a.m.	
4. SOCIAL SECURITY NUMBER 217-34-4498		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 24, 1902	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Maryland				10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Owings Mills	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 10729 Park Heights Avenue			
10f. ZIP CODE 21117-3098				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Emory Ellsworth Barber				16. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Hager			
19a. INFORMANT'S NAME (Type/Print) Edna Mae Loane				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Olmstead Road, Pikesville, Maryland 21208			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory MAR. 1		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE MAR. 1	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → urosepsis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ischemia, immobility						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 					
29c. LICENSE NUMBER D41104		29d. DATE SIGNED (Month, Day, Year) 2.27.95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ted Hale 7825 York Rd Baltimore MD 21204							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alice Dexter Jones				2. DATE OF DEATH MONTH Feb. DAY 26 YEAR 1995		3. TIME OF DEATH 5:00 P.M.									
4. SOCIAL SECURITY NUMBER 4-402-42-5657		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 17, 1918									
8. BIRTHPLACE (State or Foreign Country) Kentucky				9a. FACILITY NAME (If not institution, give street and number) 1620 Lorimer Road, 21061		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie									
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel									
10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1620 Lorimer Road,									
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced									
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: E White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Housewife and Mother									
17. FATHER'S NAME (First, Middle, Last) Sam Bentley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maryland Y Johnson											
19a. INFORMANT'S NAME (Type/Print) Ms. Lora J. Madison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Lorimer Rd., Glen Burnie, Md. 21061											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 3/1/95		20c. LOCATION — City or Town, State Baltimore, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Arrhythmia Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td>a. Chronic Lung Disease</td> <td>Approximate Interval Between Onset and Death minutes</td> </tr> <tr> <td>b. Coronary Artery Disease</td> <td>years</td> </tr> <tr> <td>c. High Blood Pressure</td> <td>years</td> </tr> <tr> <td>d. Non insulin dependent Diabetes Mellitus</td> <td>years</td> </tr> </table>								a. Chronic Lung Disease	Approximate Interval Between Onset and Death minutes	b. Coronary Artery Disease	years	c. High Blood Pressure	years	d. Non insulin dependent Diabetes Mellitus	years
a. Chronic Lung Disease	Approximate Interval Between Onset and Death minutes														
b. Coronary Artery Disease	years														
c. High Blood Pressure	years														
d. Non insulin dependent Diabetes Mellitus	years														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Lung Disease															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M									
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER James M. Londer				29c. LICENSE NUMBER D29296		29d. DATE SIGNED (Month, Day, Year) Mar 02 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GUARD M LONDER 707 E FORT AVE Balt. 21230															
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE John D. Russell											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06537

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BESSIE JONES				2. DATE OF DEATH MONTH 02 DAY 26 YEAR 1995		3. TIME OF DEATH 10:15 A M	
4. SOCIAL SECURITY NUMBER 141-26-6169		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 93 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 16, 1901		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll County		10c. CITY, TOWN OR LOCATION Mt. Airy		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4019 Harrisville Road				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper / Cook		16b. KIND OF BUSINESS/INDUSTRY Domestic	
17. FATHER'S NAME (First, Middle, Last) Robert Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Dorsey			
19a. INFORMANT'S NAME (Type/Print) Mrs. Gwendolyn Ellis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Bartholow Road Sykesville, MD 21784			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. DATE 3/4/95		20d. LOCATION — City or Town, State Mt. Airy, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SEIZURES NEW ONSET DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Sydney				29c. LICENSE NUMBER 240491		29d. DATE SIGNED (Month, Day, Year) 02/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sydney MARRAZ N.W.H.C old court Randallstown MD 21133							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06538

Item 17, g- 721,3-2-95, per f. h., dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Antoinette Klima				2. DATE OF DEATH MONTH DAY YEAR February 27 1995		3. TIME OF DEATH 11:35 A M	
4. SOCIAL SECURITY NUMBER 212-07-5492		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 17, 1903	
8. FACILITY NAME (If not institution, give street and number) Berlin Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Berlin		9c. COUNTY OF DEATH Worcester Co.	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Linthicum		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 306 Edward Avenue				10f. ZIP CODE 21090		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Expositor		16b. KIND OF BUSINESS/INDUSTRY Carey Machinery			
17. FATHER'S NAME (First, Middle, Last) Joseph (Yr) (Yerecek) Jircek				18. MOTHER'S NAME (First, Middle, Maiden Surname) ---- Marie Jircek			
19a. INFORMANT'S NAME (Type/Print) Mr. Edward Klima				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Channel Buoy Rd., Ocean City, Md. 21842			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery Mar. 2, 1995		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Arteriosclerotic Cardiovascular Disease 5 yrs					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Generalized Atherosclerosis 5 yrs					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension Non Insulin Dependent Diabetes Mellitus							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Belloso		29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 2-27-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D. 4421 BEECHWOOD PL., CRISFIELD, MD 21817							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE John W. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06539

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERL VIRGINIA LOANE				2. DATE OF DEATH MONTH FEBRUARY DAY 28 YEAR 1995		3. TIME OF DEATH 5:00 P M	
4. SOCIAL SECURITY NUMBER 212-05-1661		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-29-1906	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH SEVERNA PARK		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERNA PARK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24 TRUCKHOUSE ROAD				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRAFFIC SUPERVISOR		16b. KIND OF BUSINESS/INDUSTRY C & P TELEPHONE COMPANY			
17. FATHER'S NAME (First, Middle, Last) THOMAS OTTOWAY MARSTELLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY MAE STITLEY			
19a. INFORMANT'S NAME (Type/Print) MRS. JOYCE E. ZIMMERMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 DRUM AVENUE, N., PASADENA, MD. 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDEN PARK CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD.		20d. DATE 3/3 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 1 Second Avenue, singleton funeral home Glen Burnie, Maryland 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<p>pneumonia DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):</p> <p>hypertension DUE TO (OR AS A CONSEQUENCE OF):</p> <p>ASCVD DUE TO (OR AS A CONSEQUENCE OF):</p>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arteriosclerosis							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 22206		29d. DATE SIGNED (Month, Day, Year) 3-1-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) 273 B Peninsula Farm rd Arnold, Md 21012							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSALIE LENORE LEGUM				2. DATE OF DEATH MONTH FEB. DAY 26, YEAR 1995				3. TIME OF DEATH 8 pm					
4. SOCIAL SECURITY NUMBER 217-26-8846		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) APR. 16, 1924		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 6317 PARK HEIGHTS AVE, APT. 419						10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER				16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY SCHOOLS					
17. FATHER'S NAME (First, Middle, Last) HARRY LOUIS MINCH						18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA HILKOWITZ							
19a. INFORMANT'S NAME (Type/Print) DR. ISIDORE LEGUM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 PARK HEIGHTS AVE, APT. 419 BALTIMORE, MD 21215									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO 2-28-95 BALTIMORE, MD				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute MI Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MI - rene c. d. Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 01923C		29d. DATE SIGNED (Month, Day, Year) 4/27/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6525 W. Charles St. Thersa Ltd 21224													
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 									

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

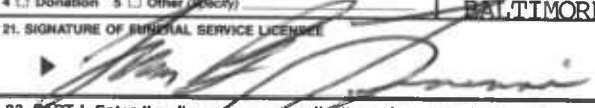
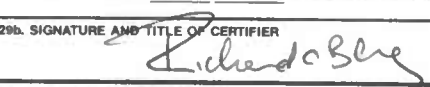

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JEFFREY A. LIPMAN				2. DATE OF DEATH MONTH FEB. DAY 26 YEAR 1995		3. TIME OF DEATH 8:15 pm M	
4. SOCIAL SECURITY NUMBER 219-56-4576		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 6, 1949	
9a. FACILITY NAME (If not institution, give street and number) 8782 CLOUD LEAP COURT				9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		9c. COUNTY OF DEATH HOWARD	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION COLUMBIA		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8782 CLOUD LEAP COURT				10f. ZIP CODE 21045 21044		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PUBLISHER		16b. KIND OF BUSINESS/INDUSTRY PRINTING			
17. FATHER'S NAME (First, Middle, Last) JONAS I. LIPMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTYE CAMPBELL			
19a. INFORMANT'S NAME (Type/Print) RICHARD D. LIPMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 TROTTERS CT., APT. T-2 BALTIMORE, MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW - 3-1-95 REISTERSTOWN, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. dehydration DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AIDS							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D20604		29d. DATE SIGNED (Month, Day, Year) 2/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard A. Berg, MD, #306,4000 Old Court Rd, Pikesville, Md 21208							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item # 6. G-film 721 per 3/3/95 P.C.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frederick D. Lane, Sr				2. DATE OF DEATH MONTH DAY YEAR February 26, 1995		3. TIME OF DEATH 12:22 A M	
4. SOCIAL SECURITY NUMBER 216-44-8728		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 24, 1947	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Md		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1041 Foxchase Road				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer		16b. KIND OF BUSINESS/INDUSTRY Baltimore City Police Department			
17. FATHER'S NAME (First, Middle, Last) Nathaniel Young				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Mae Lane			
19a. INFORMANT'S NAME (Type/Print) Almeta Lane				19b. MAILING ADDRESS (Street and Number or R.F.D., Town, State, Zip Code) Essex 1041 Foxchase Road Balto, Md 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet		20c. DATE 3395		20d. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HYPERTENSION</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John March</i>			
29c. LICENSE NUMBER D 29817				29d. DATE SIGNED (Month, Day, Year) 2/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALBERTO SANTANTONIO 6660 35th RD BALTO. MD 21204							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John March</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06543

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OLIVIA ROSE LAZZERI				2. DATE OF DEATH MONTH DAY YEAR March 1 1995		3. TIME OF DEATH 1:00 A.M.	
4. SOCIAL SECURITY NUMBER 187-18-1637		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 11 1901	
8. FACILITY NAME (If not institution, give street and number) Meriden Nursing Home Brightwood				9. CITY, TOWN OR LOCATION OF DEATH Brooklandville		10. COUNTY OF DEATH Baltimore	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Brooklyn Park	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Riverside Rd. 312		10f. ZIP CODE 21225	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Home Maker	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker				17. KIND OF BUSINESS/INDUSTRY Own Home		18. FATHER'S NAME (First, Middle, Last) Louis Giussopini	
19. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN				20. INFORMANT'S NAME (Type/Print) Eugene W. Pierelli		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMANDY DR. 2908 ELICOTT, MD. 21043	
22. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS March Baltimore, Md.		24. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark A. Romacki	
25. NAME AND ADDRESS OF FACILITY W. Dabrowski / Chojnacki, F.H.P.A. 1005 Dundalk Ave. Balt., Md 21204				26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease		Approximate Interval Between Onset and Death Years	
27. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		29. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				31. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		32. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				34. DATE OF INJURY (Month, Day, Year)		35. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				37. DESCRIBE HOW INJURY OCCURRED		38. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
39. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				40. SIGNATURE AND TITLE OF CERTIFIER John Thomas Evelius M.D.		41. LICENSE NUMBER D34952	
42. DATE SIGNED (Month, Day, Year) March 2, 1995				43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suite A. 5444 Belair Rd. North East Medical Center Balto, Md 21206		44. DATE FILED (Month, Day, Year) MAR 02 1995	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06544

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE ALICE LEMON				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28 1995		3. TIME OF DEATH 11:00 AM	
4. SOCIAL SECURITY NUMBER 213-20-4397		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 2, 1922	
9a. FACILITY NAME (If not institution, give street and number) Copper Ridge Center				9b. CITY, TOWN OR LOCATION OF DEATH Sykesville		9c. COUNTY OF DEATH Carroll County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5510 Force Road				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Binder		16b. KIND OF BUSINESS/INDUSTRY Book Bindery			
17. FATHER'S NAME (First, Middle, Last) James J. Carroll, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine J. Murname			
19a. INFORMANT'S NAME (Type/Print) Mr. Coleman L. Lemon, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1203 Sykesville, MD 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 3/3/95		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Globuloma Brain							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert L. Moss, MD				29c. LICENSE NUMBER 032882		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Moss 114 Business Center Drive							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE Reinhardt, Md			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEROY MATTHEW LINCOLN SR.				2. DATE OF DEATH MONTH DAY YEAR FEB 27 95		3. TIME OF DEATH 2:55 PM	
4. SOCIAL SECURITY NUMBER 212-44-4253		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 31, 1947	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 3535 E. NORTHERN PARKWAY		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3535 E. NORTHERN PARKWAY	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: XX		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 2 YEARS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUS DRIVER		16b. KIND OF BUSINESS/INDUSTRY MASS TRANSIT ADMINISTRATION			
17. FATHER'S NAME (First, Middle, Last) WILLIE LINCOLN SR.				18. MOTHER'S NAME (First, Middle, Last) MILDRED OWINGS LINCOLN			
19a. INFORMANT'S NAME (Type/Print) GERALENE LINCOLN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 BEAUFORT AVENUE, BALTIMORE, MARYLAND # 15			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY 3-3		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Signature</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Blunt Force Injuries of Head DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) Found 2/27/95		28b. TIME OF INJURY (Month, Day, Year) Found 1:45 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED subject beaten		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3535 E. Northern Parkway Baltimore, MD			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Signature</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE <i>Signature</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06546

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Robert Madden				2. DATE OF DEATH MONTH 02 DAY 25 YEAR 95		3. TIME OF DEATH 0055A	
4. SOCIAL SECURITY NUMBER 308-58-9149		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-01-53	
8a. FACILITY NAME (If not institution, give street and number) LLOYD F. MASON CENTER				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		8c. COUNTY OF DEATH NA	
9. RESIDENCE OF DECEASED				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. STREET AND NUMBER 9507 AXEHEAD COURT				10d. ZIP CODE 21133		10e. CITY, TOWN OR LOCATION RANDALLSTOWN	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEASED'S EDUCATION (Specify only highest grade completed) N/A		16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SAFETY CONSULTANT	
17. FATHER'S NAME (First, Middle, Last) FRANK J. MADDEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY VINSON			
19a. INFORMANT'S NAME (Type/Print) VICTOR HEGGINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 TARTAN HILL RD. RANDALLSTOWN, MD. 21133			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CROWN 3/3/95		20c. LOCATION — City or Town, State INDANAPOLIS, IND.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lewis T. Gwynn				22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Central Nervous System Toxoplasmosis DUE TO (OR AS A CONSEQUENCE OF): b. Retroviral Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 3m 10yr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Diarrhea, Dementia						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD				29c. LICENSE NUMBER J7968		29d. DATE SIGNED (Month, Day, Year) 2/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KIRSI ALLISON MD ID DIV JTH 600 N Wolfe Baltimore MD 21205							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06547

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STEPHEN MACHUSKY				2. DATE OF DEATH MONTH FEBRUARY DAY 28 YEAR 1995				3. TIME OF DEATH 11:00 A.M.				
4. SOCIAL SECURITY NUMBER 186-03-3570		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 03-15-1911		8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA	
9a. FACILITY NAME (If not institution, give street and number) 7435 FURNACE BRANCH ROAD						9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH ANNE ARUNDEL		
RESIDENCE OF DECEDENT												
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 7435 FURNACE BRANCH ROAD						10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 Never Married XX Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES XX NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CABINET MAKER				16b. KIND OF BUSINESS/INDUSTRY BOAT YARD				
17. FATHER'S NAME (First, Middle, Last) ANTHONY MACHUSKY						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY BOK						
19a. INFORMANT'S NAME (Type/Print) MARY MACHUSKY						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7435 FURNACE BRANCH ROAD, GLEN BURNIE, MD. 21060						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PK 3/3/95				20c. LOCATION — City or Town, State GLEN BURNIE, MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hyperkalemia Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Renal failure Arteriosclerotic renovascular disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pseudomonas colitis												
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER DE8387		29d. DATE SIGNED (Month, Day, Year) 1 Mar 95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. R. Gehlert MD 1600 Cranberry Glen Drive 21061												
31. DATE FILED (Month, Day, Year) MAR 02 1995												

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06548

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph B. McCoy				2. DATE OF DEATH MONTH DAY YEAR February 17, 1995				3. TIME OF DEATH 15:42 M							
4. SOCIAL SECURITY NUMBER 218-30-6222				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) February 1, 1934		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) VA Medical Center								9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH N/A			
10a. STATE MARYLAND				10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER Whittier Avenue								10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): NOT KNOWN College (1-4 or 5+): NOT KNOWN				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DENTAL ASSISTANT				16b. KIND OF BUSINESS/INDUSTRY DENTAL LAB.							
17. FATHER'S NAME (First, Middle, Last) MARCEL MCCOY								18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLA MEADE							
19a. INFORMANT'S NAME (Type/Print) SHERDINA DAVENPORT								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2532 BOYOLA NORTHWAY BALTIMORE, MARYLAND							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) GARRISON FOREST				DATE 3-6		20c. LOCATION — City or Town, State BALTIMORE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY IRVIN P. CARROLL 1712W. NORTH AVENUE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration DUE TO (OR AS A CONSEQUENCE OF): b. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): c. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER MRO S90		29d. DATE SIGNED (Month, Day, Year) 2/28/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donna Hines MD 10 North Greene Street, Baltimore, MD 21201															
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0906-510
B.K.S
95-062

95 06549

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel Mae Maddox				2. DATE OF DEATH MONTH FEB. DAY 19 YEAR 95		3. TIME OF DEATH 2006 P M					
4. SOCIAL SECURITY NUMBER 216-09-7520D		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7. DATE OF BIRTH (Month, Day, Year) Sept 10, 1907		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) 827 N. ARLINGTON AVENUE APT. #1007				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A				
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 827 North Arlington Avenue Apt 1007				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laundry Worker		16b. KIND OF BUSINESS/INDUSTRY Argyle Laundry							
17. FATHER'S NAME (First, Middle, Last) Isaac Berryman				16. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Ann Curry							
19a. INFORMANT'S NAME (Type/Print) Elizabeth Perkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Grantley Road Baltimore, Maryland 21215							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery Feb 25 Baltimore, Maryland		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, INC 2501 Gwynns Falls Pkwy Baltimore, Maryland 21216									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease complicated by thermal injury DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old myocardial infarction DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 2/19/95		28b. TIME OF INJURY 2000 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT IN HOUSE FIRE			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) APARTMENT		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE MD 827 N. ARLINGTON AVE							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 20, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JANE E. MURDOCK				2. DATE OF DEATH MONTH 2 DAY 24 YEAR 1995		3. TIME OF DEATH 5:30 AM	
4. SOCIAL SECURITY NUMBER 171-24-9720		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 12 30	
9a. FACILITY NAME (If not Institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2902 Hilldale Avenue				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) None		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		17. KIND OF BUSINESS/INDUSTRY NA			
17. FATHER'S NAME (First, Middle, Last) John Murdock				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Conva			
19a. INFORMANT'S NAME (Type/Print) Kay Smith				19b. MAILING ADDRESS Sutton 8 East Stoon, Morreston, N.J. 08057			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory 2/27		20c. LOCATION — City or Town, State Beltsville, Md. 20705			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Peter J. [Signature]				22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto, Md. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → TOTAL BODY FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
SEPSIS							
DUE TO (OR AS A CONSEQUENCE OF):							
PERITONITIS							
DUE TO (OR AS A CONSEQUENCE OF):							
PERFORATE DUODENAL ULCER							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated Intravascular Coagulopathy							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Juan Paredez M.D. STAFF Surgeon				29c. LICENSE NUMBER 0-18933		29d. DATE SIGNED (Month, Day, Year) 02-24-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUAN PAREDEZ M.D. 2600 Liberty Heights Baltimore MD 21210							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06551

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN HELEN MAZZOLA				2. DATE OF DEATH MONTH DAY YEAR FEB. 24, 1995		3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 215-10-3377		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-15-05	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. CITY, TOWN OR LOCATION OF DEATH Dundalk		10. COUNTY OF DEATH Baltimore	
11. FACILITY NAME (If not institution, give street and number) 3417 Dunhaven Rd..							
12. RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3417 Dunhaven Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 yrs College (1-4 or 5+) Custodian				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian		16b. KIND OF BUSINESS/INDUSTRY N.E. Police Station	
17. FATHER'S NAME (First, Middle, Last) Walter Modzelewsky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Modzelewsky Borlowski			
19a. INFORMANT'S NAME (Type/Print) Virginia Modjesky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Dunhaven Rd. Dundalk, Md. 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 2-27-95 Balto., Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083				22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE DAY							
b. CHRONIC OBSTRUCTIVE LUNG DISEASE YEARS							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC HEART DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER B. C. Veneracion Jr M.D.				29c. LICENSE NUMBER D13664		29d. DATE SIGNED (Month, Day, Year) 2/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. C. VENERACION JR M.D. 1576 WEARFT BLVD STE 22, BALTO MD 21222							
31. DATE FILED (Month, Day, Year) MAR 6 1995				32. REGISTRAR'S SIGNATURE John A. ...			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

14



95-1005-510

B.K.S

95-069

Item 19a 3-2-95 Film G721 W.H.Per F/H

95 06552

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARSHALL DEAN MOORE				2. DATE OF DEATH MONTH FEB. DAY 25 YEAR 95		3. TIME OF DEATH 2037 P M	
4. SOCIAL SECURITY NUMBER 213-76-1727		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 28, 1958	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL E.R.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE (RANDALLSTOWN)		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10 CINNAMON CIRCLE apt. 2D				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) WILLIAM SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) VERNA MOORE			
19a. INFORMANT'S NAME (Type/Print) VERNA MOORE HAYES Haynes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 NICHOLS DRIVE, GREENVILLE, NORTH CAROLINA 27858			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. LOCATION — City or Town, State 3-2 LANSDOWNE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephanie K. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. STAB WOUND OF BACK DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> SURVIVOR/OUTPATIENT <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 2 25 95		28b. TIME OF INJURY PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SWING LATER STAB BED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1325 EAST FAYETTE BALTIMORE MD	
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Davidson</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Davidson 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06553

Item 6 3-2-95 Film G721 W.H.Per F/H

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) PAIGE MEREDYTH MITCHELL			2. DATE OF DEATH MONTH FEB DAY 25 YEAR 1995		3. TIME OF DEATH 1755 M
4. SOCIAL SECURITY NUMBER N/A	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) N/A YRS.	7. DATE OF BIRTH (Month, Day, Year) FEB. 22, 1995	8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY
RESIDENCE OF DECEASED					
10a. STATE MARYLAND	10b. COUNTY PRINCE GEORGES	10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7902-12 BAYSHORE DRIVE		10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) NONE			
16. KIND OF BUSINESS/INDUSTRY NONE		17. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NONE			
17. FATHER'S NAME (First, Middle, Last) RICHARD MITCHELL			18. MOTHER'S NAME (First, Middle, Maiden Surname) KAREN KANE		
19. INFORMANT'S NAME (Type/Print) MR. RICHARD MITCHELL			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902-12 BAYSHORE DRIVE LAUREL, MD 20707		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW		20c. LOCATION — City or Town, State 2-28-95 REISTERSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. congenital hydrocephalus DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death 3 DAY
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER H 45952		29d. DATE SIGNED (Month, Day, Year) 25 Feb 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORY DOWNING Holy Cross Hospital 1500 Forest Glen Rd Silver Spring, MD					
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART 1, 27, PER MEO FILM G-721 3/21/95

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER G. MOORE JR.				2. DATE OF DEATH MONTH DAY YEAR FEB 25 95		3. TIME OF DEATH 8:05 P.M.	
4. SOCIAL SECURITY NUMBER 218-86-9023		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 24, 1969	
8. BIRTHPLACE (State or Foreign Country) GEORGIA				9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1517 NORTHWICK ROAD	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 10 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUS ATTENDANT		16b. KIND OF BUSINESS/INDUSTRY HOFFMAN BUS COMPANY	
17. FATHER'S NAME (First, Middle, Last) WALTER G. MOORE SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE P. BELLINGER			
19a. INFORMANT'S NAME (Type/Print) ANNIE P. SEESS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 NORTHWICK ROAD, BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY 3-4		20c. LOCATION — City or Town, State PIKESVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley K. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDITIS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Clark MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06555

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE MUSGROVE				2. DATE OF DEATH MONTH DAY YEAR February 27, 1995		3. TIME OF DEATH 5:25 P M	
4. SOCIAL SECURITY NUMBER 219-34-1754		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 24, 1925	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Little Orleans				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Route 1 Box 127	
10f. ZIP CODE 21766				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic	
17. FATHER'S NAME (First, Middle, Last) Joe Delph				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Orick			
19a. INFORMANT'S NAME (Type/Print) Mr. Thomas E. Musgrove				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 127 Little Orleans, MD 21766			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Linthicum Chapel Cemetery 3/2/95		20c. LOCATION — City or Town, State Clarksville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian D. Haight</i>				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION 2-DAYS DUE TO (OR AS A CONSEQUENCE OF): b. CAD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Raver</i> Dr. James Raver				29c. LICENSE NUMBER D 18769		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. James Raver Memorial Hospital Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>Shirley Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Nole				2. DATE OF DEATH MONTH Feb DAY 28 YEAR 1995		3. TIME OF DEATH 11:40 PM	
4. SOCIAL SECURITY NUMBER 248-42-6564		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-1-30	
8. BIRTHPLACE (State or Foreign Country) S.C.				9a. FACILITY NAME (If not institution, give street and number) Howard Co. General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Columbia	
9c. COUNTY OF DEATH Howard				10a. STATE Md.		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Columbia				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6334 Cedar Lane	
10f. ZIP CODE 21044				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) NA			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crain Operator				16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Allie Nole			
19a. INFORMANT'S NAME (Type/Print) Mildred Nole Ash				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 Plymouth Rd. Baltimore MD 21214			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Mt. Zion A.M.E. 3/4/95			
20c. LOCATION — City or Town, State Jamesstown, S.C.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE John March			
22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave.				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gangrene Right leg DUE TO (OR AS A CONSEQUENCE OF): Arterial occlusion Right leg DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 days 2 days 10 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 2/28/95			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Steven Geller MD				29c. LICENSE NUMBER d 34613			
29d. DATE SIGNED (Month, Day, Year) 2/28/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Geller MD, 9501 Old Annapolis Rd, Ellicott City MD 21042			
31. DATE FILED MAR 02 1995				32. SIGNATURE OF REGISTRAR John March			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

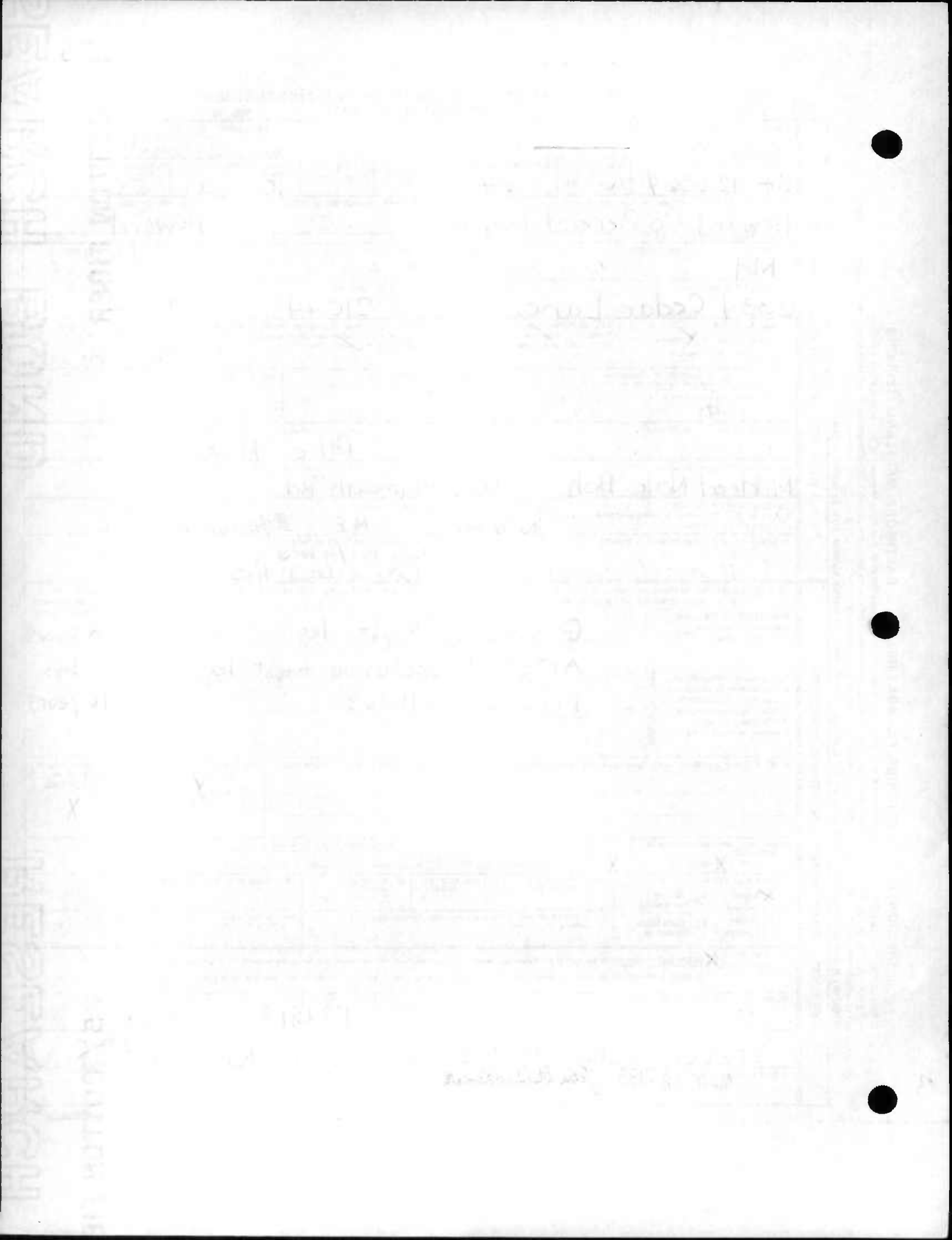
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM E OSTERHAUS				2. DATE OF DEATH MONTH Feb. DAY 26 YEAR 1995		3. TIME OF DEATH 11:00 p. M	
4. SOCIAL SECURITY NUMBER 216-10-3461		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1911	
9a. FACILITY NAME (If not institution, give street and number) Lorien Frankford Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4347 Berger Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Lord Baltimore Press			
17. FATHER'S NAME (First, Middle, Last) William Osterhaus				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Neuberger			
19a. INFORMANT'S NAME (Type/Print) Joan Mancini (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7608 Bagley Avenue, Baltimore, Md. 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 3/2/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):							
b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary Tract Infection Parkinson's Disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lee Tannenbaum MD				29c. LICENSE NUMBER D39763		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Tannenbaum, MD 21 Crossroads Dr. Suite #330 Owings Mills, MD 21117							
31. DATE FILLED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06558

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN PRESSLEY				2. DATE OF DEATH MONTH 2 - DAY 26 - YEAR 95		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 212-16-4765		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-13-00	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH N/A			
9a. FACILITY NAME (If not institution, give street and number) IRVINGTON KNOLLS CARE CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MD		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3002 CHESLEA TERRACE				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) BTH College (13-16 or 17+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE'S AIDE		16b. KIND OF BUSINESS/INDUSTRY HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) UNK.				18. MOTHER'S NAME (First, Middle, Maiden Surname) STARVIS			
19a. INFORMANT'S NAME (Type/Print) ETHEL JACOBS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 APPLETON ST. BALTIMORE MD. 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WINDHAM		20c. LOCATION — City or Town, State BALTIMORE MD		20d. DATE 3/3/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY GARY P. MARSH FUNERAL HOME PA, 270 FREDERICK BLVD BALT. MD. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Aspiration Pneumonia							
b. Cerebrovascular Accident							
c. Hypertension							
d.							
Approximate interval between Onset and Death 2 weeks							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Vasantha Kumar				29c. LICENSE NUMBER D42510		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. VASANTHA KUMAR 821. N. EUTAW ST, SUITE 407 MD 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995 John H. Hester							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0933-510
DWG

95 06559

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/17/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LINDA LEE PECORA				2. DATE OF DEATH MONTH DAY YEAR FEB. 21 95		3. TIME OF DEATH 1230P M			
4. SOCIAL SECURITY NUMBER 215-66-4701		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 21, 1952		8. BIRTHPLACE (State or Foreign Country) Md	
9a. FACILITY NAME (If not institution, give street and number) 4703 SCHLEY AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH NA	
10a. STATE Md				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4703 Schley Avenue				10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) Clerical	
16. KIND OF BUSINESS/INDUSTRY UNKNOWN				17. FATHER'S NAME (First, Middle, Last) Paul Mackin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Zimmerman	
19a. INFORMANT'S NAME (Type/Print) Mary Zimmerman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Larch Ct. Edgewood, Md. 21040				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory				20c. DATE 2/23		20d. LOCATION — City or Town, State Beltsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phillip Starks</i>				22. NAME AND ADDRESS OF FACILITY Bradley Ashton Funeral Home 2134 Willow Spring Road, Balto, Md. 21222				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → FATTY LIVER Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) FEB. 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201				31. DATE FILED (Month, Day, Year) MAR 6 2 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Perry				2. DATE OF DEATH MONTH - DAY - YEAR 2 - 21 - 95		3. TIME OF DEATH 3:00 P M	
4. SOCIAL SECURITY NUMBER 218-22-9109		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 6, 1930	
8. BIRTHPLACE (State or Foreign Country) Md				9a. FACILITY NAME (If not institution, give street and number) md General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Balto	
9c. COUNTY OF DEATH N/A				10a. STATE md			
10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Balto		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1510 Gilmore St	
10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A	
16b. KIND OF BUSINESS/INDUSTRY N/A		17. FATHER'S NAME (First, Middle, Last) Ernest		18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Perry		19a. INFORMANT'S NAME (Type/Print) Linda Taylor	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Armitage Ct. Balto, Md 21244		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Mt. Zion Cemetery 3/1/95		20c. LOCATION — City or Town, State Landsdowne, md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Elton		22. NAME AND ADDRESS OF FACILITY March Aft-West 4300 Wabash Ave		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multi-Organ Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): AIDS b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death: unknown		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Georgia Cu, M.D.	
29c. LICENSE NUMBER 89226		29d. DATE SIGNED (Month, Day, Year) 2-21-95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Georgia Cu, M.D. c/o Maryland General Hospital		31. DATE FILED (Month, Day, Year) MAR 02 1995	
32. REGISTRAR'S SIGNATURE John Davidson Randall							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06561

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THELMA PRELL				2. DATE OF DEATH MONTH Feb DAY 28 YEAR 95		3. TIME OF DEATH 12:40 PM	
4. SOCIAL SECURITY NUMBER 219-10-8983		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-6-13		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 520 N. Linwood Ave.				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Albert Myers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Crawford			
19a. INFORMANT'S NAME (Type/Print) Robert Myers Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1271 Pecan Ct. Gibson Island, MD 21056			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 3-1-95		20c. LOCATION — City or Town, State Catonsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis S. Kelly				22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Dementia DUE TO (OR AS A CONSEQUENCE OF): c. COPD DUE TO (OR AS A CONSEQUENCE OF): d. TIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arteriosclerosis							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael J. [Signature]				29c. LICENSE NUMBER 022206		29d. DATE SIGNED (Month, Day, Year) March 1 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 273 B Peninsula Lane Rd Annapolis MD 21012							
31. DATE FILED (Month, Day, Year) MAR 1 1995				32. REGISTRAR'S SIGNATURE Juan [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


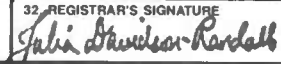
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06562

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE M. PREISINGER				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28 1995		3. TIME OF DEATH 09:29 A^M	
4. SOCIAL SECURITY NUMBER 216-09-3639		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 6, 1910	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 412 4242 Sheldon Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Switchboard Operator		16b. KIND OF BUSINESS/INDUSTRY Linen Company			
17. FATHER'S NAME (First, Middle, Last) John V. Ullrich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Wellein			
19a. INFORMANT'S NAME (Type/Print) William L. Preisinger (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9410 Furrow Avenue, Ellicott City, Md. 21042			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith		DATE 3/4/95		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. VENTRICULAR TACHYCARDIA AND FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERIOSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): d. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASC. DIS.					
Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 30 min 6 DAYS YRS. YRS.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPOTHYROIDISM							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Charles E. Brown, M.D. Assoc. Pathologist		29c. LICENSE NUMBER DO 1008		29d. DATE SIGNED (Month, Day, Year) MARCH 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES E. BROWN, M.D. 201 E. UNIV. PARKWAY BALTO., MD. -21218							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

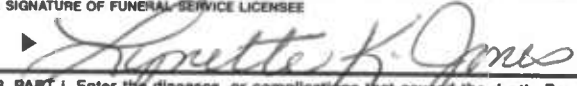
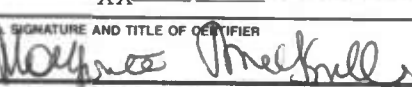
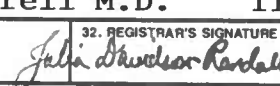
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JULIAN PARKER				2. DATE OF DEATH MONTH FEB. DAY 26 YEAR 95		3. TIME OF DEATH 2116 P M							
4. SOCIAL SECURITY NUMBER 218-07-6979		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 5, 1913							
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9. FACILITY NAME (If not institution, give street and number) 1808 EAST MADISON STREET		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY							
11. RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY n/a 10c. CITY, TOWN OR LOCATION BALTIMORE 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				12. STREET AND NUMBER 1808 EAST MADISON STREET		13. ZIP CODE 21205							
14. CITIZEN OF WHAT COUNTRY? UNITED STATES				15. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES							
17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				18. RACE — American Indian, Black, White, etc. Specify: BLACK		19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PORTER							
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 TH College (1-4 or 5+) -				21. KIND OF BUSINESS/INDUSTRY n/a		22. FATHER'S NAME (First, Middle, Last) JOHN PARKER							
23. MOTHER'S NAME (First, Middle, Maiden Surname) LULA PROMISE				24. INFORMANT'S NAME (Type/Print) WILBERT PARKER		25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 E. MADISON ST, BALTIMORE, MD 21205							
26. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK		28. DATE 3-3							
29. LOCATION — City or Town, State RANDALLSTOWN, MD				30. SIGNATURE OF FUNERAL SERVICE LICENSEE 		31. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INSPECTION		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29a. SIGNATURE AND TITLE OF CERTIFIER 		29b. LICENSE NUMBER O..CM.E		29c. DATE SIGNED (Month, Day, Year) FEB. 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201								31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06564

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>Raymond Phair III</u>				2. DATE OF DEATH MONTH <u>Feb.</u> DAY <u>22</u> YEAR <u>95</u>		3. TIME OF DEATH <u>4:20 A M</u>	
4. SOCIAL SECURITY NUMBER <u>220-86-1465</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>33</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>DEC. 2, 1961</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>JOHNS HOPKINS HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH <u>MARYLAND</u>	
10a. STATE <u>MARYLAND</u>				10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>4665 PARK HEIGHTS AVE.</u>		10f. ZIP CODE <u>21215</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>				11. MARITAL STATUS <u>SINGLE</u> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12TH GRADE</u> College (1-4 or 5+) <u>COMPUTER OPERATOR</u>				16. KIND OF BUSINESS/INDUSTRY <u>BANK</u>			
17. FATHER'S NAME (First, Middle, Last) <u>RAYMOND PHAIR JR.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>VONZELLA HOBBS</u>			
19a. INFORMANT'S NAME (Type/Print) <u>VONZELLA HOBBS</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4665 PARK HEIGHTS AVE. BALTIMORE, MD 21215</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <u>MT. ZION CEMETERY 2-27-95 BALTIMORE, MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Charles D. Brown</u>				22. NAME AND ADDRESS OF FACILITY <u>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Retroviral Syndrome</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death <u>10yr</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Candida esophagitis</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] MD</u>				29c. LICENSE NUMBER <u>J7968</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/23/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KIRSI ALLISON MD 1D DIVISION ROSS 1159 600 N Wolfe JHH Baltimore MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 6 2 1995</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06565

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Allmond Quast</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 26 1995</i>				3. TIME OF DEATH <i>11:55 A M</i>	
4. SOCIAL SECURITY NUMBER <i>214-74-6195</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>95</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <i>March 9, 1899</i>				8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>				9c. COUNTY OF DEATH <i>Harford</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Kingsville</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2511 Whitt Road</i>				10f. ZIP CODE <i>21087</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>William Walter Allmond, Jr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emma Catherine Roane</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Charles H. Quast, Jr. (son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2511 Whitt Road, Kingsville, MD 21087</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i>		DATE <i>3/1</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Heart Failure</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>Aortic Stenosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <i>3 YRS</i> <i>3 YRS</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Urinary Tract Infection</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Nowakowski MD</i>				29c. LICENSE NUMBER <i>DO 8096</i>		29d. DATE SIGNED (Month, Day, Year) <i>February 26 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Andrew Nowakowski 125 N. Main St. Bel Air, Md. 21014</i>									
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>Jahia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NAOMI J. REINHARDT				2. DATE OF DEATH MONTH FEB. DAY 27 YEAR 1995		3. TIME OF DEATH 21:30	
4. SOCIAL SECURITY NUMBER 216-36-5118		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 2, 1904	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore (Brooklyn)		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 410 Pontiac Avenue,				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Housewife and Mother	
17. FATHER'S NAME (First, Middle, Last) Henry Fangman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Bahlmann			
19a. INFORMANT'S NAME (Type/Print) Mrs. Marie Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Seward Ave., Baltimore, Md. 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery Mar 2, 1995 Baltimore, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. hypoxia DUE TO (OR AS A CONSEQUENCE OF):							
b. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
c. 3/p explosion by lightning and myeloplastic cholesterolemia DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ewa Rachocka				29c. LICENSE NUMBER D01892		29d. DATE SIGNED (Month, Day, Year) Feb/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EWA RACHOCKA M.D. ST AGNES HOSPITAL 900 CATON AVE, BALTIMORE							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN-MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed by the attending physician, or other qualified person, within 72 hours after death. It must be signed by the attending physician, or other qualified person, and must be filed within 72 hours after death with the Registrar of Health and Mental Hygiene. If item 28 is marked, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Registrar of Health and Mental Hygiene.

AM

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICKEY RIVENBURG				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28 1995		3. TIME OF DEATH 7:35A	
4. SOCIAL SECURITY NUMBER 218-92-4084		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 18 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05 25 76	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION MILLERSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8123 FOXWELL ROAD				10f. ZIP CODE 21108		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 01		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NEVER WORKED		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) GERALD E. RIVENBURG JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIELOU A. LOWAY			
19a. INFORMANT'S NAME (Type/Print) MARIELOU A. LOWAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8123 FOXWELL ROAD-MILLERSVILLE, MD. 21108			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS		DATE 3/7		20c. LOCATION — City or Town, State CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
23. PART I. Enter the diseases, conditions, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 30 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. COMA DUE TO (OR AS A CONSEQUENCE OF):					
		c. BRAIN STEM HERNIATION DUE TO (OR AS A CONSEQUENCE OF):					
		d. BRAIN TUMOR DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYDROCEPHALUS / SEPSIS. TRACHE; G-tube							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) S. J. PAO, MD - 4000 Mitchellville Road; #220; BOWE - MD - 20716.							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

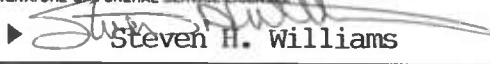

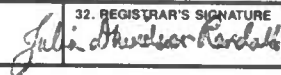
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06568

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/14/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SAMUEL C. RIEDEL, JR.				2. DATE OF DEATH MONTH DAY YEAR FEB. 23 1995		3. TIME OF DEATH 11:06 PM	
4. SOCIAL SECURITY NUMBER 217-50-9904		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 15, 1948	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION PASADENA				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1835 Cremen Road	
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIETNAM				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) VIETNAM				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRUCKING INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) SAMUEL CHRISTOPHER RIEDEL, JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA ELVERA KOCH			
19a. INFORMANT'S NAME (Type/Print) MRS. ANNA E. RIEDEL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1835 Cremen Road, Pasadena, MD 21122			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 2/25 Baltimore, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, MD 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC AND COCAINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 2/23/95		28b. TIME OF INJURY FOUND 9:36 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) PARKED AUTO		28e. DESCRIBE HOW INJURY OCCURRED UNKNOWN					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Donald G. Wright MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB. 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06569

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Otie Elaine Riese H</i>				2. DATE OF DEATH MONTH DAY YEAR <i>03 01 95</i>		3. TIME OF DEATH <i>5:33 A M</i>	
4. SOCIAL SECURITY NUMBER <i>212-20-4140</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 7, 1925</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto. City, Md.</i>		9c. COUNTY OF DEATH <i>None</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>None</i>		10c. CITY, TOWN OR LOCATION <i>Balto. City, Md.</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>3623 St. Victor St.</i>			
10f. ZIP CODE <i>21225</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>5th. Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>George McCauley</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Nettie McCauley</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Deborah E. Dixon</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1417 Rowe Dr. Glen Burnie, Md. 21061</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Mem. Park 3/3/95</i>		20c. LOCATION — City or Town, State <i>Glen Burnie, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <i>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bacteremia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>3 days</i> <i>3 days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus, small bowel obstruction, morbid obesity</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas K. Murray MD</i>				29c. LICENSE NUMBER <i>P08177</i>		29d. DATE SIGNED (Month/Day, Year) <i>3/01/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Thomas K. Murray, MD 301 St. Paul Place, Baltimore, MD 21202</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06570

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIOLA D. Simms				2. DATE OF DEATH MONTH FEB DAY 23 YEAR 1995		3. TIME OF DEATH 2305 M	
4. SOCIAL SECURITY NUMBER 217 26 8916		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 20, 1932	
9a. FACILITY NAME (If not institution, give street and number) DEATON MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5816 NARCISSUS AVENUE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S. OF A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATHS		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACJK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DATA PROCESS OPERATOR		16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY			
17. FATHER'S NAME (First, Middle, Last) JOHN OTHER ALLEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH IRENE MOULDEN			
19a. INFORMANT'S NAME (Type/Print) MR. SLYVESTER E. SIMMS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2603 ALLENDALE RD. BALTIMORE, MD. 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK 3/1/95		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lewis T. Gwynn				22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, HYPERTENSION, RESPIRATORY FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						Approximate Interval Between Onset and Death 3 WKS. 10 YRS.	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Brian C. Wallace				29c. LICENSE NUMBER D31136		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE MD, 611 S. CHARLES ST. BALTIMORE, MD 21200							
31. DATE FILED (Month, Day, Year) MAR 2 1995		32. REGISTRAR'S SIGNATURE Jane [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06571

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE ROBERT SPURRIER				2. DATE OF DEATH MONTH DAY YEAR February 28, 1995		3. TIME OF DEATH 10:00P	
4. SOCIAL SECURITY NUMBER 219-22-9114		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 6, 1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Baltimore			
10a. FACILITY NAME (If not institution, give street and number) Meridian Multi Medical				10b. CITY, TOWN OR LOCATION OF DEATH Towson		10c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6503 Old Orchard Road				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman		16b. KIND OF BUSINESS/INDUSTRY Steel			
17. FATHER'S NAME (First, Middle, Last) Robert George Spurrier				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Elizabeth Charlet			
19a. INFORMANT'S NAME (Type/Print) Joan A. Spurrier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Old Orchard Road Baltimore, Maryland 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 3/4		20c. LOCATION — City or Town, State Lutherville, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis H. L. Kenak</i>	
22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastrointestinal bleeding Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Stress ulcers c. Cerebrovascular accident d.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christine J. Lafferman MD</i>				29c. LICENSE NUMBER D33211		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christine J. Lafferman 2360 W. Joppa Road #302 Lutherville, Maryland 21093							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN JULIAN STELMACH				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 26, 1995				3. TIME OF DEATH 5:30 PM	
4. SOCIAL SECURITY NUMBER 213-10-8222		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 12, 1910		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) CATON MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD		10b. COUNTY N/A.		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 839 PONTIAC AVENUE				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENGINEER				16b. KIND OF BUSINESS/INDUSTRY FLYNN & EMERIC COMPANY			
17. FATHER'S NAME (First, Middle, Last) JULIAN STELMACH				18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE KLESCZEWSKI					
19a. INFORMANT'S NAME (Type/Print) SISTER MARIE STELMACH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3865 BELLEAU DR. # 8, Lexington, KY 40517					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 2/28 BALTIMORE, MD				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore MD 21225					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible acute cardiac ischemia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cardiovascular disease c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death few hrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent small bowel obstruction 2° adhesive band CVA; Sideroblastic anemia								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Geetha Raja MD				29c. LICENSE NUMBER D27541		29d. DATE SIGNED (Month, Day, Year) Feb 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEETHA RAJA 4367 - Hollins Ferry Rd Site 3B, Balt MD-21227									
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06573

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DAVID H. STARR				2. DATE OF DEATH MONTH FEB DAY 27 YEAR 1995		3. TIME OF DEATH 1100 A M	
4. SOCIAL SECURITY NUMBER 212-30-4354		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 11, 1934	
9a. FACILITY NAME (If not institution, give street and number) LEVINDALE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6938 GLENHEIGHTS AVE.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) SALESMAN		16b. KIND OF BUSINESS/INDUSTRY JEWELRY			
17. FATHER'S NAME (First, Middle, Last) IRVING STARR				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA CAPLAN			
19a. INFORMANT'S NAME (Type/Print) MRS. EILEEN OLINER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7240 PARK HEIGHTS AVE, UNIT 101 BALTIMORE, MD 21215			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OHEB SHALOM MEMORIAL PARK 3-1-95		20c. LOCATION — City or Town, State REISTERSTOWN, MD		20d. DATE 3-1-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John D. Lewis</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOPULMONARY FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death mins 2 WKS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Matthew McNabney MD</i>				29c. LICENSE NUMBER D45757		29d. DATE SIGNED (Month, Day, Year) FEB 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATTHEW MCNABNEY MD 2434 W. BELVEDERE BALT, MD 21215							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John D. Lewis</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06574

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Matthew Swerdloff</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>25</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1540 P</i>	
4. SOCIAL SECURITY NUMBER <i>220-24-1502</i>		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>64</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>DEC. 9, 1930</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>ANNE ARUNDEL MEDICAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>ANNAPOLIS</i>		9c. COUNTY OF DEATH <i>ANNE ARUNDEL</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>55 PENNY LANE</i>				10f. ZIP CODE <i>21209</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>ATTORNEY</i>		15b. KIND OF BUSINESS/INDUSTRY <i>LAW</i>			
17. FATHER'S NAME (First, Middle, Last) <i>SOL SWERDLOFF</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNE CARP</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MRS. ARLENE B. SWERDLOFF</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>55 PENNY LANE, BALTO., MD. 21209</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HAR SINAI CONGREGATION</i>		DATE <i>2/28/95</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Cottle</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CARDIAC ARREST</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ACUTE INFERIOR MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>2 HOURS</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month/Day, Year) <i>2/25/95</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Kennedy</i>				29c. LICENSE NUMBER <i>544837</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/25/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>MAR 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davis-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and is intended to give a general impression of the progress made.

2. The second part of the report deals with the results of the work done during the year. It is a summary of the results of the work and is intended to give a general impression of the progress made.

Submitted by

CH. B. BROWN

1926

1926

1926

95 06575

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) GEORGE CHARLES SMITH				2. DATE OF DEATH MONTH FEB DAY 27 YEAR 1995		3. TIME OF DEATH 6:50 A. M.		
4. SOCIAL SECURITY NUMBER 216-24-4553		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/13/30		
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A		
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION TOWSON		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1614 MYAMBY ROAD				
10f. ZIP CODE 21286				10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTOMER RELATIONS		15b. KIND OF BUSINESS/INDUSTRY B G & E		15c. CITY, TOWN OR LOCATION TOWSON		
17. FATHER'S NAME (First, Middle, Last) GEORGE PETER SMITH				16. MOTHER'S NAME (First, Middle, Maiden Surname) BARBARA ADELHARDT				
19a. INFORMANT'S NAME (Type/Print) MARY R. SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 MYAMBY ROAD TOWSON, MD 21286				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM.		20c. LOCATION — City or Town, State 3/2/95 OWINGS MILLS, MD		20d. DATE 3/2/95		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina J. Kopych</i>				22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIO-							Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
b. UNUSUAL DISEASE								
c. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERLIPIDEMIA							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Faust Q. Aquino Jr. MD</i>		29c. LICENSE NUMBER D14697		29d. DATE SIGNED (Month, Day, Year) 02-27-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FAUST Q. AQUINO JR. MD 8713 HARRISON RD. BALTO, MD								
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE <i>John B. Baker</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD ALEXANDER SZPARA, SR				2. DATE OF DEATH MONTH FEB. DAY 23 YEAR 1995		3. TIME OF DEATH 3:45P M	
4. SOCIAL SECURITY NUMBER 212-07-1013		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/27/17	
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH MARYLAND	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION HILLENDALE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1707 ORLANDO ROAD			
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) CONTRACT SPEC.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FEDERAL GOVT.		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) FRANK SZPARA				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE RZUBROWSKA			
19a. INFORMANT'S NAME (Type/Print) REGINA M. SZPARA				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 ORLANDO ROAD HILLENDALE, MD 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK 2/27/95		20c. LOCATION — City or Town, State HILLENDALE, MD		20d. DATE 2/27/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR DYSRHYTHMIAS DUE TO (OR AS A CONSEQUENCE OF): b. ISCHEMIC CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. HYPERTENSION, HYPERLIPIDEMIA Approximate Interval Between Onset and Death imed. 4 years 20 yrs 50 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, embolic CVA, Mediastinal lymphoma DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Serena R. Nolan MD				29c. LICENSE NUMBER D25010		29d. DATE SIGNED (Month, Day, Year) Feb. 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Serena R. Nolan, M.D. 8035A Harford Rd. Baltimore, Md. 21234							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06577

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN WILSON		2. DATE OF DEATH MONTH FEB. DAY 28 YEAR 1995		3. TIME OF DEATH 3:50 P M
4. SOCIAL SECURITY NUMBER 418-38-6978	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 29, 1929	8. BIRTHPLACE (State or Foreign Country) Alabama
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A
10a. STATE Maryland		10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1153 North Calhoun Street		
10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educational Aide		16b. KIND OF BUSINESS/INDUSTRY Balto Cuty School System		
17. FATHER'S NAME (First, Middle, Last) Joel Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Gordan		
19a. INFORMANT'S NAME (Type/Print) Carl H. Wilson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1153 North Calhoun Street Baltimore, MD 21217		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD National Memorial Park Mar 4		20c. LOCATION — City or Town, State Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, INC 2501 Gwynns Falls Parkway Baltimore, Maryland 21216		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → VENTRICULAR FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST AWTE MYOCARDIAL INFARCTION SEVERE CORONARY ARTERY DISEASE				Approximate interval between Onset and Death 20 MIN > 24 HRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MITRAL REGURGITATION SIP MVR (ST. JUDGE'S) END STAGE RENAL DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER MANUEL C. TANGUAY, M.D.		
29c. LICENSE NUMBER D46440		29d. DATE SIGNED (Month, Day, Year) FEB. 28, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EMMANUEL C. TANGUAY, M.D. / GOOD SAMARITAN HOSP'L OF MD				
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE John A. Anderson		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <u>Elijah Williams, Jr</u>				2. DATE OF DEATH MONTH <u>02</u> DAY <u>27</u> YEAR <u>95</u>		3. TIME OF DEATH <u>18:42</u> ^P	
4. SOCIAL SECURITY NUMBER <u>219-52-4654</u>		5. SEX <u>1</u> M <u>2</u> F		8. AGE (In yrs. last birthday) <u>44</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>March 13 1950</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Mercy Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO				10e. STREET AND NUMBER <u>2023 Raynor Avenue</u>			
10f. ZIP CODE <u>21217</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College 5+</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Teacher</u>		16b. KIND OF BUSINESS/INDUSTRY <u>City Balto City Public School Sys</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Beulah Alston</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elijah Williams Sr.</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sherman Williams</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2727 West Garrison Avenue Balto., MD 21215</u>			
20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Arbutus Memorial Park</u>		DATE <u>Mar 6</u>		20c. LOCATION — City or Town, State <u>Baltimore County, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Vernon R. Bailey</u>				22. NAME AND ADDRESS OF FACILITY <u>Nutter Funreal Homes, Inc</u> <u>2501 Gwynns Falls Parkway</u> <u>Baltimore, MD 21216</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acquired Immundeficiency Syndrome</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> Outpatient <u>3</u> DDA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)					
27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Should not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Vernon R. Bailey, MD</u>				29c. LICENSE NUMBER <u>MD0744</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/27/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>K. Korzick; Mercy Hospital; Balto, MD 21202</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 02 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Hardell</u>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERMAN WRIGHT				2. DATE OF DEATH MONTH 02 DAY 27 YEAR 95		3. TIME OF DEATH 7:45 P.M.	
4. SOCIAL SECURITY NUMBER 577-28-8989		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 11, 1922	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 3717 Springdale Avenue			
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dry Cleaner		16b. KIND OF BUSINESS/INDUSTRY Self Employed	
17. FATHER'S NAME (First, Middle, Last) George Wright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Ebron			
19a. INFORMANT'S NAME (Type/Print) Annie B. Wright				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3717 Springdale Avenue Baltimore, MD 21216			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD National Memorial Park Mar 4		20c. LOCATION — City or Town, State Laurel, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter	
22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BILATERAL PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): CEREBRO-VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): DIABETES MELLITUS HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN					
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accidental 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D 23300		29d. DATE SIGNED (Month, Day, Year) 2.27.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUDHAR D. FATEL 2600 Liberty Medical Center 2600 Liberty Medical Center Baltimore MD 21215							
31. DATE FILED (Month, Day, Year) MAR 02 1995		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1069-510

B.K.S

Item10b 3-2-95 FilmG721 W.H.Per F/H

95 06580

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS J. WHITE				2. DATE OF DEATH MONTH DAY YEAR FEB. 28 95		3. TIME OF DEATH 0825 A M	
4. SOCIAL SECURITY NUMBER 217-01-0442		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-12-06	
9a. FACILITY NAME (If not institution, give street and number) 1206 NORTH CURLEY STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH NONE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1205 N. CURLEY STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRAIN OPERATOR		16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL CO.			
17. FATHER'S NAME (First, Middle, Last) RICHARD WHITE				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGIE			
19a. INFORMANT'S NAME (Type/Print) CYNTHIA N. JOHNSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7119 MINNA RD. BALTO, MD. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEM 3-4-95		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i>				22. NAME AND ADDRESS OF FACILITY BALTIMORE, MARYLAND 21213 CALVIN B. SCRUGGS FUNERAL HOME			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INSPECTION							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 02 1995				32. REGISTRAR'S SIGNATURE <i>John Michael Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERTHA ROSE ZOELLER				2. DATE OF DEATH MONTH FEBRUARY DAY 28 YEAR 1995		3. TIME OF DEATH 12:15 PM	
4. SOCIAL SECURITY NUMBER 212-09-8682		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05-15-1919	
9a. FACILITY NAME (If not institution, give street and number) 1451 WASHINGTON AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH SEVERN		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1451 WASHINGTON AVENUE			
10f. ZIP CODE 21144				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) HERBERT E. KNICKMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE FICHER			
19a. INFORMANT'S NAME (Type/Print) MR. EARL W. ZOELLER				19b. MAILING ADDRESS Sycamore 100 SYCAMORE ROAD, BALTIMORE, MD. 21226			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK 3/3/95		20c. LOCATION — City or Town, State ELKRIDGE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Avenue, S.W. Glen Burnie, Maryland 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death 2 3/4 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 031551		29d. DATE SIGNED (Month, Day, Year) February 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Russell R. DeLuca, M.D. 1600 S. Craig Highway, Glen Burnie, Md. 21061							
31. DATE OF DEATH (Month, Day, Year) MAR 02 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET VIOLA ALBIKER				2. DATE OF DEATH MONTH MAR DAY 1 YEAR 95		3. TIME OF DEATH 15.30 M	
4. SOCIAL SECURITY NUMBER 215-01-7244		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 06, 1905	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Ellicott City				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2713 Brinkleigh Drive	
10f. ZIP CODE 21042		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8-th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Retail Sales	
17. FATHER'S NAME (First, Middle, Last) Charles Frederick Sorensen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Kraushaar			
19a. INFORMANT'S NAME (Type/Print) Helen Longan German				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Brinkleigh Drive Ellicott City, MD 21042			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Mortuary, crematorium, or other place) Metro Crematory, Inc. 03/02/95		20c. LOCATION — City or Town, State Baltimore, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald	
22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF exacerbation. DUE TO (OR AS A CONSEQUENCE OF): b. CHF DUE TO (OR AS A CONSEQUENCE OF): c. COPD DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 20 days 710 yr. 710 yr.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A/56 HTN				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Eve Reichen M.D.				29c. LICENSE NUMBER DO1892		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EWA RACHOCKA ST AGNES HOSPITAL 900 CATON AVE BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) MAR 3 1995		32. REGISTRAR'S SIGNATURE John A. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06583

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Irving BANKS				2. DATE OF DEATH MONTH DAY YEAR February 23, 1995		3. TIME OF DEATH 10:25P M	
4. SOCIAL SECURITY NUMBER 223-28-4099		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-5-23	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Perry Point VA Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point, Maryland	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1401 Odessa Thomas Court Apt.11	
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW2				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (14 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Upholsterer		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) Oscar H. Banks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Robinson			
19a. INFORMANT'S NAME (Type/Print) Shirley Tobias				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Odessa Thomas Court, Baltimore, Md 21205			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 3/2/95		20c. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley Tobias</i>				22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road Chatman-Harris F/H Baltimore, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Laryngeal Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel L. Dries M.D.				29c. LICENSE NUMBER D46224		29d. DATE SIGNED (Month, Day, Year) 2/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel Dries, MD, VAMC Perry Point, Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06584

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAY ANITA BALTIMORE				2. DATE OF DEATH MONTH February DAY 23 YEAR 1995		3. TIME OF DEATH 8:25 a.m.	
4. SOCIAL SECURITY NUMBER 219-10-2652		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 26, 1912	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Parkville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5 PALMA CT				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) AUGUSTUS BROWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Wilson			
19a. INFORMANT'S NAME (Type/Print) Joan J. WINDSOR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 PALMA CT			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem		OATE 2/27/95		20c. LOCATION — City or Town, State Balto. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY EVANS Chapel of Memories 8800 HARFORD Rd. Balto. Md 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Tachycardia heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 1 hour
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prior stroke							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 015561		29d. DATE SIGNED (Month, Day, Year) 2/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Lippman 2401 Oslen Ln, Towson, Md 21204							
31. DATE FILED (Month, Day, Year) MAR 03 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06585

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN MARIE BROWN				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 27 1995		3. TIME OF DEATH 12:45 A M	
4. SOCIAL SECURITY NUMBER 215 017081A		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 11 1907	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Keswick Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 8853 Lake Ave.			
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 YRS College (13-16) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY STEEL SILVER CO.			
17. FATHER'S NAME (First, Middle, Last) GEORGE M. BROWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA M. BRAVER			
19a. INFORMANT'S NAME (Type/Print) MARGARET RESS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 EAST LAKE AVE. BALTIMORE, MARYLAND 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		20d. DATE 25	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY EVANS CHARLOTT OF MOURNERS 8800 HARFORD ROAD - PARKVILLE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALZHEIMER'S DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCERD EMBLECISTIS							Approximate Interval Between Onset and Death YRS
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 12399		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES O. BROWN III, JR. Keswick 800 U. 40th St. Baltimore, MD 21211							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06586

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel BARHIGHT				2. DATE OF DEATH MONTH March DAY 2 YEAR 1995		3. TIME OF DEATH 1:47 A M	
4. SOCIAL SECURITY NUMBER 215 28 0962		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH MONTH April DAY 13 YEAR 1901	
9a. FACILITY NAME (If not institution, give street and number) Franklin Sq. Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4 Compass Rd.			
10f. ZIP CODE 21220				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) William Flecknoe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Sooby			
19a. INFORMANT'S NAME (Type/Print) Ray F. Barhight, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2228 Firethorn Rd. Baltimore, MD 21220			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, street, city, state, zip code) Green Mount Crematory 3/3/95		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, MD 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Parietal Meningioma b. DUE TO (OR AS A CONSEQUENCE OF): Hypertension c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D44793		29d. DATE SIGNED (Month, Day, Year) March 2, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ali Sanai, M.D. 6730 Holabird Avenue Baltimore, MD 21222							
31. DATE FILED (Month, Day, Year) MAR 3 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06587

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Henry Benney				2. DATE OF DEATH MONTH DAY YEAR March 2 1995		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 214-10-6656		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/16/08	
9a. FACILITY NAME (If not institution, give street and number) 1519 Ridge Road				9b. CITY, TOWN OR LOCATION OF DEATH Whiteford, MD.		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Whiteford, MD.	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1519 Ridge Road				10f. ZIP CODE 21160		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Steel Mill	
17. FATHER'S NAME (First, Middle, Last) Joseph Reese Benney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Hickman			
19a. INFORMANT'S NAME (Type/Print) Karen L. Nelka				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8065 Midhaven Rd. Baltimore, MD. 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 3/3/95		20c. LOCATION — City or Town, State Baltimore City			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>DEHYDRATION</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>ALZHEIMER'S DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death DAYS YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>URINARY TRACT INFECTION; OBSTRUCTIVE UROPATHY; ADENOCARCINOMA PROSTATE</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER M-7320		29d. DATE SIGNED (Month, Day, Year) 03/02/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3623 WHITEFORD RD. WHITEFORD MD. 21160-1196							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ISAAC BURGESS				2. DATE OF DEATH MONTH FEB. DAY 24 YEAR 95		3. TIME OF DEATH 1350 P M	
4. SOCIAL SECURITY NUMBER 248-27-5672		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 13-1967	
8. BIRTHPLACE (State or Foreign Country) S.C.				9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2121 WINDSOR GARDEN LANE #147	
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) laborer		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) DELORIS BURGESS			
19a. INFORMANT'S NAME (Type/Print) DELORIS BURGESS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 WINDSOR GARDEN LANE Balto. Md 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEM. PARK 3-4-95		20c. LOCATION — City or Town, State Balto. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Chron				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME - WEST 4300 WABASH AVE. BALTO. MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HANGING DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year) 2 24 95		28b. TIME OF INJURY P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT HANGED SELF		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) JAIL CELL		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 571 REISTERSTOWN RD BALTIMORE MD			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert M. Thiele				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary Ann A. Koran 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Freida H. Brown				2. DATE OF DEATH MONTH 12 DAY 25 YEAR 95		3. TIME OF DEATH 1135 P M					
4. SOCIAL SECURITY NUMBER 216-32-1532		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 14, 1916		8. BIRTHPLACE (State or Foreign Country) Md			
9a. FACILITY NAME (If not institution, give street and number) Cherrywood N/H				9b. CITY, TOWN OR LOCATION OF DEATH Balto Reisterstown			9c. COUNTY OF DEATH Reisterstown				
10a. STATE Md		10b. COUNTY MA		10c. CITY, TOWN OR LOCATION Balto				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3426 Piedmont Avenue				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? U S A					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+1 13 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher Aide			16b. KIND OF BUSINESS/INDUSTRY Baltimore City Schools				
17. FATHER'S NAME (First, Middle, Last) Charles Scott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Della Pinkney							
19a. INFORMANT'S NAME (Type/Print) Julia Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Candyfuff Road Reisterstown, Md 21136							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 3195			DATE Arbutus, Md		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Breast cancer — metastatic DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Diabetes								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO.		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Julia Clark					29c. LICENSE NUMBER 027123			29d. DATE SIGNED (Month, Day, Year) 2/25/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia Clark 700 main st Reisterstown md 21136											
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE Julia Clark									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06590

Item 4, Film 721, 3/16/95, 1t
Item 21, Film 721, 3/73/95, 1t1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MINNIE LOIS M. BOSSLER				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 95		3. TIME OF DEATH 2220 P M	
4. SOCIAL SECURITY NUMBER 820-05-9208		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-18-15	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Balto. City	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6611 Johnny Cake Road				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) H.S. --		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Elijah T. Barbour				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Kelly			
19a. INFORMANT'S NAME (Type/Print) Diana G. Guglielmetti				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5936 Oakland Road Sykesville, Md. 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park March 4, 1995		20c. LOCATION — City or Town, State Sykesville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Haight</i>				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 30 minutes							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIED (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David V. T. [Signature]</i>				29c. LICENSE NUMBER D35572		29d. DATE SIGNED (Month, Day, Year) 3-1-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 900 Caton Avenue-21229							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE <i>John Hamilton-Bordall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06591

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel Cannon				2. DATE OF DEATH MONTH Feb DAY 25 YEAR 1995		3. TIME OF DEATH 8:08 A.M.	
4. SOCIAL SECURITY NUMBER 218-76-5344		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-15-15	
9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2449 SHIRLEY AVE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY HOUSE WIFE			
17. FATHER'S NAME (First, Middle, Last) HARRY CANNON				18. MOTHER'S NAME (First, Middle, Maiden Surname) DAISEY CANNON			
19a. INFORMANT'S NAME (Type/Print) ARNITTA WILSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 WAYNE AVE. BALTIMORE, MD. 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		DATE 3/1		20c. LOCATION — City or Town, State LANSDOWNE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George E. Wicks III</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder Cancer Seizure Disorder							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residences <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.				29c. LICENSE NUMBER D41365		29d. DATE SIGNED (Month, Day, Year) Feb 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights Ave 21216							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John D. Smith</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06592

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ann F. Cole</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 2, 1995</i>		3. TIME OF DEATH <i>1:15A. M</i>	
4. SOCIAL SECURITY NUMBER <i>213-16-4040</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 18, 1920</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>4111 Century Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>md.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4111 Century Rd.</i>				10f. ZIP CODE <i>21206</i>		10g. CITIZEN OF WHAT COUNTRY? <i>I U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Head Cashier</i>		16b. KIND OF BUSINESS/INDUSTRY <i>GBMC Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Jacob Scheener</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Florence</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Nelson E. Scheener</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5500 Plainfield Ave. Baltimore, md. 21206</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Druid Ridge Cem.</i>		20c. LOCATION — City or Town, State <i>Balto., Md.</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph Smith</i>				22. NAME AND ADDRESS OF FACILITY <i>Hantley Millen Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Small Cell Lung Carcinoma</i> Approximate Interval Between Onset and Death <i>21 mo</i> Sequitively list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Husky MD</i>				29c. LICENSE NUMBER <i>D36814</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/2/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard E. Husky 7505 Osler Dr. Suite 504 Towson 21204</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 3 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06593

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Rose M. Copenhagen</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>28</i> YEAR <i>95</i>		3. TIME OF DEATH <i>12:55 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-05-3972</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>92</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 10, 1903</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Golden Age Guest Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Sykesville</i>		9c. COUNTY OF DEATH <i>Carroll</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Sykesville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1442 Buckhorn Road</i>				10f. ZIP CODE <i>21784</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (8-12)</i> <i>12th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Customer Service Rep.</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Hecht Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Joseph G. Fitzpatrick</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Frances Costello</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Evelyn McDonald</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5814 Oklahoma Road Sykesville, MD 21784</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Loudon Park Cemetery</i>		DATE <i>3/4</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Covey</i>				22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic obstructive pulmonary disease</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patrick A. Turnos</i>		29c. LICENSE NUMBER <i>D20806</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Patrick A. Turnos MD 1425 Liberty Road Eldersburg, MD 21784</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 03 1995</i>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06594

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul George CUSIC Sr.				2. DATE OF DEATH MONTH DAY YEAR February 27, 1995		3. TIME OF DEATH 11:10 am. M	
4. SOCIAL SECURITY NUMBER 215-01-1959		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 28, 1912	
8. BIRTHPLACE (State or Foreign Country) OHIO				9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Bowleys Quarters				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 910 Frog Mortar Road	
10f. ZIP CODE 21220				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 6th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Equipment Operator		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Paul Jerome Cusic				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Butterworth			
19a. INFORMANT'S NAME (Type/Print) Paul G. Cusic Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3328 Choptank Ave. Baltimore Md. 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 3/2/95		20c. LOCATION — City or Town, State Rossville Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis							
b. Lung cancer							
c. Due to (OR AS A CONSEQUENCE OF):							
d. Due to (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER RD1763		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Anthony Campbell D.O. 9000 Franklin Sq Dr. Balt. MD 21237							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louis L. DUNN				2. DATE OF DEATH MONTH February DAY 27, 1995 YEAR				3. TIME OF DEATH 5:55 A M		
4. SOCIAL SECURITY NUMBER 577-42-7886		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24, 1932		8. BIRTHPLACE (State or Foreign Country) N.C.		
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hosptial				9b. CITY, TOWN OR LOCATION OF DEATH Balto				9c. COUNTY OF DEATH Baltimore County		
10a. STATE Md			10b. COUNTY N/A			10c. CITY, TOWN OR LOCATION Owings Mills			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9317-9017 Lyonswoods Drive				10f. ZIP CODE 21117				10g. CITIZEN OF WHAT COUNTRY? U S A		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) N/A College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter				16b. KIND OF BUSINESS/INDUSTRY Construction Construction Co		
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown						
19a. INFORMANT'S NAME (Type/Print) Helen H. Dickerson Helen Dickerson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9317 Lyonswood Drive Owings Mills, Md 21117						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet 3295				20c. LOCATION — City or Town, State Owings Mills, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
				28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D22409		
				29d. DATE SIGNED (Month, Day, Year) 3/2/95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph DiAntonio, Jr. M.D. 7401 Osler Dr Balto, Md 21204										
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delivered to the funeral home for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06596

Items#17.19.b. G-film 721 per F.H 3/3/95 P.C

FOR
1. STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gladys B. ERLBECK</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 27 95</i>		3. TIME OF DEATH <i>6:05 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-28-0821</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>79</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>SEPT. 15, 1915</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Lansdowne</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3900 Mc Dowell Lane</i>				10f. ZIP CODE <i>21227</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Poblett</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mollie Constantine</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Judy O'Connor</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3900 Mc Dowell Lane Baltimore, Maryland 21227</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Memorial Park 3/3/95</i>		20c. LOCATION — City or Town, State <i>Glen Burnie, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Therese J. Polynick</i>				22. NAME AND ADDRESS OF FACILITY <i>Mc Cully Funeral Home of Brooklyn 237 East Patapsco Avenue Baltimore, MD. 21225</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Malignant Pleural Effusion</i> DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death <i>7 days</i> <i>1 1/2 years</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Metastatic Breast Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Changjian Chen MD</i>				29c. LICENSE NUMBER <i>D-81174</i>		29d. DATE SIGNED (Month, Day, Year) <i>February 27, 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Changjian Chen, 7888 Americana Circle #101, Glen Burnie, MD 21060</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 03 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia A. Kessler-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06597

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVANS Paul				2. DATE OF DEATH MONTH Feb DAY 28 YEAR 95		3. TIME OF DEATH 12:40 PM	
4. SOCIAL SECURITY NUMBER 220-05-5599		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 11, 1912	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Villa St. Michael		10. CITY, TOWN OR LOCATION OF DEATH Baltimore	
11. RESIDENCE OF DECEDENT				12. COUNTY OF DEATH N/A		13. COUNTY OF DEATH N/A	
14. STATE Maryland		15. COUNTY N/A		16. CITY, TOWN OR LOCATION Baltimore		17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
18. STREET AND NUMBER 124 W. Franklin St. apt. 709				19. ZIP CODE 21201		20. CITIZEN OF WHAT COUNTRY? USA	
21. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: Black	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13-16 or 17+) 0		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Houseperson		27. KIND OF BUSINESS/INDUSTRY Catholic Home			
28. FATHER'S NAME (First, Middle, Last) John Evans				29. MOTHER'S NAME (First, Middle, Maiden Surname) Arnetta Segers			
30. INFORMANT'S NAME (Type, Print) Lillian Evans				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 W. Franklin St. Balto., Md. 21201			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Garrison Forest 3/4/95		34. LOCATION — City or Town, State Balto., Co., Md.			
35. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ				36. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto., Md. 21216			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE Approximate Interval Between Onset and Death 2 wks Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PROSTATE CANCER c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES MELLITUS							
38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
41. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		42. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
43. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		44. DATE OF INJURY (Month, Day, Year)		45. TIME OF INJURY M		46. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		48. DESCRIBE HOW INJURY OCCURED					
49. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
50. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. SIGNATURE AND TITLE OF CERTIFIER Tasneem Lakhani				52. LICENSE NUMBER D 28525		53. DATE SIGNED (Month, Day, Year) 3/1/95	
54. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208							
55. DATE FILED (Month, Day, Year) MAR 03 1995				56. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06598

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH JOHN SAMSTER, SR.				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 25 1995		3. TIME OF DEATH 10 P.M.	
4. SOCIAL SECURITY NUMBER 392-16-5026		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 16 1922	
8. BIRTHPLACE (State or Foreign Country) Wisconsin		9a. FACILITY NAME (If not institution, give street and number) 244 EAST PAOONIA ROAD		9b. CITY, TOWN OR LOCATION OF DEATH Timonium		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION Timonium	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 244 EAST PAOONIA ROAD		10f. ZIP CODE 21093	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II.	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (14 or 5+) 7 YRS.	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VICE PRESIDENT				16b. KIND OF BUSINESS/INDUSTRY U.S.F.+G.		17. FATHER'S NAME (First, Middle, Last) HENRY W. SAMSTER	
18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA E. BURNS				19a. INFORMANT'S NAME (Type/Print) SILVER A. SAMSTER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 EAST PAOONIA ROAD Timonium, MD.	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MEMORIAL 3-1		20c. LOCATION — City or Town, State Timonium, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHARLES OF CHIMES 2325 YORK ROAD - Timonium		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC MELANOMA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D34827	
29d. DATE SIGNED (Month, Day, Year) FEB. 26, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JAMES G. SODLING 7401 OSTER DRIVE - Towson		31. DATE FILED (Month, Day, Year) MAR 03 1995	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive hand, and the dates are in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second.

2. The second part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

3. The third part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

4. The fourth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

5. The fifth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

6. The sixth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

7. The seventh part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

8. The eighth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

9. The ninth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

10. The tenth part of the document is a series of lines of text, which appear to be a continuation of the record or a separate entry. The text is written in the same cursive hand as the names, and is organized into a single column.

95 06599

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSETTA D. EVANS				2. DATE OF DEATH MONTH 03 DAY 02 YEAR 1995		3. TIME OF DEATH 10:21 am	
4. SOCIAL SECURITY NUMBER 217-24-7632		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-4-30	
8a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Turners Station		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 101 Walnut Ave				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Unk.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Home Maker			
17. FATHER'S NAME (First, Middle, Last) Horace Mickey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Dunvall			
19a. INFORMANT'S NAME (Type/Print) Reginald Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Walnut Ave. Balto., MD 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 3/7		20c. LOCATION — City or Town, State Baltimore, MD		20d. DATE 3/7	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Homes 1701 Laurels St. Balto., MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):							
b. Liver failure DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Danoff MD</i>				29c. LICENSE NUMBER L5124		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. Danoff Johns Hopkins Hospital							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John D. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06600

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James E. FINN				2. DATE OF DEATH MONTH DAY YEAR February 25, 1995		3. TIME OF DEATH 9:50 A. M.	
4. SOCIAL SECURITY NUMBER 220-18-6575		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1926	
9a. FACILITY NAME (If not Institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rose Dale		9c. COUNTY OF DEATH Baltimore County	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PARKVILLE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3015 TEXAS AVE.			
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W-W-II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) POLICEMAN				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) POLICEMAN		16b. KIND OF BUSINESS/INDUSTRY CITY OF BALTIMORE	
17. FATHER'S NAME (First, Middle, Last) CHESTER M. Finn				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE T. HUGGS			
19a. INFORMANT'S NAME (Type/Print) Emma M. Finn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 TEXAS AVE. PARKVILLE, MARYLAND 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 3-1		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Multiple Organ Failure</u> DUE TO (OR AS A CONSEQUENCE OF): 16 hrs							
b. <u>Gastrointestinal Bleeding</u> DUE TO (OR AS A CONSEQUENCE OF): 16 hrs							
c. <u>Cirrhosis and Ascites</u> DUE TO (OR AS A CONSEQUENCE OF): 3 weeks							
d. <u>Probable Hepatocellular Cancer</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Difficulty Breathing</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER AF232.8412-1764		29d. DATE SIGNED (Month, Day, Year) 2/25/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marilyn Conlon, MD 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06601

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen R. Giernalczyk				2. DATE OF DEATH MONTH DAY YEAR February 27, 1995		3. TIME OF DEATH 1:30p M	
4. SOCIAL SECURITY NUMBER 214-03-2468		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/11/1911	
9a. FACILITY NAME (If not institution, give street and number) 1205 Basil Ct.				9b. CITY, TOWN OR LOCATION OF DEATH Belair		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Belair		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1205 Basil Ct.				10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Can Company			
17. FATHER'S NAME (First, Middle, Last) Antoni Rutkowski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Bujanowski			
19a. INFORMANT'S NAME (Type/Print) Myra DePasquale				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Basil Ct. Belair, Md. 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Rosary Cemetery 03-04		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester Street, Balto., Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → C.V.A. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David S. Dunn</i>				29c. LICENSE NUMBER 232255		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 2105 LAUREL BUSH RD							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE <i>John Buckner</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROXIE ELIZABETH Garrity				2. DATE OF DEATH MONTH DAY YEAR February 22, 1995		3. TIME OF DEATH 12:26 A.M.	
4. SOCIAL SECURITY NUMBER 219-18-2302		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) APR 12 1909	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON	
9c. COUNTY OF DEATH HARFORD				10a. STATE MARYLAND		10b. COUNTY HARFORD	
10c. CITY, TOWN OR LOCATION BLAIR				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 203 YORKSHIRE WAY E.	
10f. ZIP CODE 21014				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YRS. College (1-4 or 5+) AT HOME				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Wesley CARROLL HART				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA MAYBELL GIBBONS			
19a. INFORMANT'S NAME (Type/Print) EDWARD J. GARRITY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 YORKSHIRE WAY E. BLAIR, MARYLAND 21014			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CH. 2-24-95		20c. LOCATION — City or Town, State Baltimore, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - BLAIR, P.A. 21050 2 NEWPORT DRIVE, FOREST HILL MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Abdominal Aortic Aneurysm, Rupture Approximate interval Between Onset and Death 20 minutes Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> <p>Abdominal Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Arteriosclerotic Disease DUE TO (OR AS A CONSEQUENCE OF):</p> </div> <div> <p>1 year</p> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] P. Bonovich MD				29c. LICENSE NUMBER D05593		29d. DATE SIGNED (Month, Day, Year) February 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 754 Hickory Avenue Bel Air MARYLAND 21014							
31. DATE FILED (Month, Day, Year) MAR 3 1995				32. REGISTRAR'S SIGNATURE [Signature]			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06603

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elmer George GRAY				2. DATE OF DEATH MONTH DAY YEAR March 1, 1995		3. TIME OF DEATH 5:30 A M	
4. SOCIAL SECURITY NUMBER 213-07-1654		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5300 Dew Garth Circle	
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) Welder			
16. KIND OF BUSINESS/INDUSTRY Beth Steel				17. FATHER'S NAME (First, Middle, Last) George Gray			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence ==				19a. INFORMANT'S NAME (Type/Print) Scott Gray			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5300 Dwe Garth Circle Baltimore MD. 21206				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 3/6/95 Baltimore MD.				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Edema Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Congestive Cardiacopathy DUE TO (OR AS A CONSEQUENCE OF): Emphysema DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Martha J. Henderson MD				29c. LICENSE NUMBER D21846		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9105 Franklin Square Drive. Baltimore Md.							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John A. Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR FUNERAL HOME (PHYSICIAN): The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06604

Item#12.G-film 721 per F.H 3/3/95 P.C

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter Albert Guidice, Jr.						2. DATE OF DEATH MONTH DAY YEAR March 1, 1995		3. TIME OF DEATH 12:30 A. M.	
4. SOCIAL SECURITY NUMBER 219-28-4117		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 5, 1932		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 7827 Saint Boniface Lane						9b. CITY, TOWN OR LOCATION OF DEATH Dundalk		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 7827 Saint Boniface Lane				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (14 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Yard Foreman		16b. KIND OF BUSINESS/INDUSTRY City Maintenance			
17. FATHER'S NAME (First, Middle, Last) William Albert Guidice, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Unknown Unknown			
19a. INFORMANT'S NAME (Type/Print) Mildred Loretta Guidice				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7827 Saint Boniface Lane, Baltimore, Maryland 21222					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 3/4/95		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road Baltimore, Md. - 21206					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death 1 minute	
		b. Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF):						2 years	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Linda A. Walsh MD						29c. LICENSE NUMBER D34208		29d. DATE SIGNED (Month, Day, Year) 3/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINDA A. WALSH MD 1012 OLD NORTH PT RD, BALT, MD 21224									
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06605

Item #17. G-film 721 per F.H 3/3/95 P.C

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Oliver Hastings, Jr.				2. DATE OF DEATH MONTH DAY YEAR Feb. 28, 1995		3. TIME OF DEATH 2:15 P M	
4. SOCIAL SECURITY NUMBER 217-16-0385		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 11, 1921	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3648 Benson Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore City				10a. STATE Maryland		10b. COUNTY Baltimore City	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3648 Benson Avenue	
10f. ZIP CODE 21227				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lithographer		16b. KIND OF BUSINESS/INDUSTRY National Can Corporation	
17. FATHER'S NAME (First, Middle, Last) George Oliver Hasth Hastings, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Mae Vollers			
19a. INFORMANT'S NAME (Type/Print) Mr. Donald E. Hastings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 990 Elm Road Baltimore, Maryland 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. LOCATION — City or Town, State 3/3 Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M Jenkins</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular Disease</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Cirrhosis of Liver</i> b. c. d. Approximate Interval Between Onset and Death <i>5 YRS</i> <i>1 YR</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TYPE OF CERTIFIER <i>David C. Tolson</i>				29c. LICENSE NUMBER 037913 MD		29d. DATE SIGNED (Month, Day, Year) 3/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis A. SALAS 3449 Wilkins Ave Suite 310 Baltimore 21229							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06606

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred C. Horky				2. DATE OF DEATH MONTH DAY YEAR February 25, 1995		3. TIME OF DEATH 4:45 P.M.	
4. SOCIAL SECURITY NUMBER 212-28-8395		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/29/1930	
9a. FACILITY NAME (If not institution, give street and number) 634 South Eaton Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH City	
10a. STATE MD		10b. COUNTY City		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 634 South Eaton Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Packer		16b. KIND OF BUSINESS/INDUSTRY Factory			
17. FATHER'S NAME (First, Middle, Last) John F. Horky Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Harrington			
19a. INFORMANT'S NAME (Type/Print) John Horky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 South Eaton Street, Balto., Md. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cemetery 3-1		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester Street Balto. Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Sharfman</i>				29c. LICENSE NUMBER 038409		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Sharfman 4940 Eastern Ave Baltimore 21209							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text, possibly a signature or date, located in the lower right quadrant of the page.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN SIVEWRIGHT HAMMETT				2. DATE OF DEATH MONTH DAY YEAR FEB 24, 1995		3. TIME OF DEATH 10:57 A M					
4. SOCIAL SECURITY NUMBER 511 34 2896		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 25, 1931		8. BIRTHPLACE (State or Foreign Country) CANADA			
9a. FACILITY NAME (If not institution, give street and number) 301 PRESTON STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH			
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PERRY HALL				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5 CANOGA PLACE T.B.				10f. ZIP CODE 21226		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 4 YRS.		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Collection Supervisor		15b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND							
17. FATHER'S NAME (First, Middle, Last) William Sivewright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Fisher Brodie							
19a. INFORMANT'S NAME (Type/Print) SANDRA KUONSS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 12673 Kearns Utah 84119							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST		DATE 2-3		20c. LOCATION — City or Town, State GARRISON, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL-BELAIR, P.A. 21000 3 NEWPORT DRIVE FOREST HILL, Maryland							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO partial		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) office building									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 25, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE [Signature]							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06608

Item #4. G-film 721 per 3/10/95 P.C.
Items #1.19.b. 22 G-film 721 per F.H 3/3/95 P.C.1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARBARA Lynn HALE				2. DATE OF DEATH MONTH Feb DAY 25 YEAR 1995		3. TIME OF DEATH 8:56 pm	
4. SOCIAL SECURITY NUMBER 214-66-5214		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 3, 1957	
8. BIRTHPLACE (State or Foreign Country) Maryland		9. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
10. RESIDENCE OF DECEDENT				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Timonium		10e. ZIP CODE 21093	
10f. STREET AND NUMBER 16 A Mistywood Circle		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker	
16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) William Ernest Keirle, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Mae Castor		19. INFORMANT'S NAME (Type/Print) Charles J. Hale, Sr.	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 A Mistywood Circle, Timonium, MD 21093		20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. Mar		20c. LOCATION — City or Town, State Timonium, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary		22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE PERITONITIS DUE TO (OR AS A CONSEQUENCE OF): b. LEAKAGE OF ULCER NEAR GASTROENTEROSTOMY SITE DUE TO (OR AS A CONSEQUENCE OF): 3 c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29c. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29d. SIGNATURE AND TITLE OF CERTIFIER Samuel C. H. Lee, M.D.		29e. LICENSE NUMBER D 06234	
29f. DATE SIGNED (Month, Day, Year) 2/26/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMUEL C. H. LEE, M.D., 7620 YORK RD., TOWSON, MD. 21204			
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE Julia Thurston-Hardell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jamie Huddleston				2. DATE OF DEATH MONTH 2 DAY 24 YEAR 95		3. TIME OF DEATH 8:40 A M	
4. SOCIAL SECURITY NUMBER 212-86-7005		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-30-61	
8. BIRTHPLACE (State or Foreign Country) MD.				9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH MD.				10a. STATE MD.		10b. COUNTY MD.	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1217 W. FAYETTE STREET	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) HOMELESS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMELESS		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN	
17. FATHER'S NAME (First, Middle, Last) JAMES HUDDLESTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) PEGGY POWELL			
19a. INFORMANT'S NAME (Type/Print) LISA GRIBBLE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 S. EATON AVE. BALTO. MD. 21224			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 03-03-95		20c. LOCATION — City or Town, State CATONSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia-Deficiency resulting from Acquired Immune a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death: unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER I. Gendelman M.D.				29c. LICENSE NUMBER 89212		29d. DATE SIGNED (Month, Day, Year) 2/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Inna Gendelman, M.D. c/o Maryland General Hospital							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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95 06610

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lillian C. Humbert</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 02 1995</i>		3. TIME OF DEATH <i>0138 A M</i>	
4. SOCIAL SECURITY NUMBER <i>213 03 7476</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>90</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 08, 1904</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Sykesville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7200 Third Ave.</i>				10f. ZIP CODE <i>21784</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>H.S.</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Underwood Chalmers</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gertrude Butterfield</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Edward Humbert</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4928 Avoka Ave. Ellicott City, Md. 21246w</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery March 6, 1995 Baltimore, Md.</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Haight</i>				22. NAME AND ADDRESS OF FACILITY <i>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic atrial fibrillation, ASCVD, COPD</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D Roggen MD</i>				29c. LICENSE NUMBER <i>D35844</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 02, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>D. Roggen 5401 Old Court Rd. Randallstown MD 21133</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 03 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06611

Item# 1.film 721 per F.H 3/3/95 P.C

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leonard Jones Leonard C. Jones				2. DATE OF DEATH MONTH 02 DAY 26 YEAR 95		3. TIME OF DEATH 2:47P M	
4. SOCIAL SECURITY NUMBER 220-66-1752		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 11, 1957 Maryland	
9a. FACILITY NAME (If not institution, give street and number) Liberty medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4229 Park Heights Avenue				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) James M. Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Hardy			
19a. INFORMANT'S NAME (Type/Print) Anna Mae Goss				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2769 W. North Avenue Baltimore, Maryland			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 3/4/95		20c. LOCATION — City or Town, State Brooklyn, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Darryl Harris				22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road Chatman-Harris F/H Baltimore, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Bilateral Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Intravenous Drug Abuse DUE TO (OR AS A CONSEQUENCE OF): d. Aortic insufficiency							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kerran Elder MD Attending				29c. LICENSE NUMBER D38993		29d. DATE SIGNED (Month, Day, Year) 2/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kerran Elder 2600 Liberty Hgts Baltimore MD 21205							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE Johi Davidson-Rodall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06612

Item#1. g- film 721 per F.H 3/3/95 P.C

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME Robert Ada Viola Johnson				2. DATE OF DEATH MONTH DAY YEAR February 28 1995		3. TIME OF DEATH 12:34 PM	
4. SOCIAL SECURITY NUMBER 215-32-0693		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 94 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 1, 1899		8. BIRTHPLACE (State or Foreign Country) N. Carolina	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY n/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4815 Old Frederick Road				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Cranston Electric Co.			
17. FATHER'S NAME (First, Middle, Last) Edward Roberts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Hargrove			
19a. INFORMANT'S NAME (Type/Print) Melvin Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 Maine Avenue Baltimore, Maryland 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 3/4/95		20c. LOCATION — City or Town, State Baltimore, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dewey Harris				22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road Chatman-Harris F/H Baltimore, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. CAD DUE TO (OR AS A CONSEQUENCE OF): d. CHF Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death years 48 hours years 24 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN, advanced age							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER K Burgess MD				29c. LICENSE NUMBER A032789		29d. DATE SIGNED (Month, Day, Year) February 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHLEEN BURGESS 29 SOUTH PACA ST, BALTIMORE MD 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GARRETT T. JACKSON				2. DATE OF DEATH MONTH DAY YEAR FEB 24, 1995		3. TIME OF DEATH 2:01 P M					
4. SOCIAL SECURITY NUMBER 218-86-5550		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 25 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-06-69		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) IN REAR OF #2 SOUTH GILMAN STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH NA				
10a. STATE MD.		10b. COUNTY BA		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 1721 W. LANVALE STREET				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY UNK							
17. FATHER'S NAME (First, Middle, Last) CHARLES JACKSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERALDINE BOYD							
19a. INFORMANT'S NAME (Type/Print) REGINALD JACKSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 PACEBROOK CT. BALTO. MD. 21207							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 03-04-95		OATE		20c. LOCATION — City or Town, State LANSDOWNE MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H P.A. 638 N. GILMOR STREET 21217							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) IN YARD									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 2 24 95		28b. TIME OF INJURY 1358 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECTS NOT BY POLICE			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) YARD		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 25 GILMAN ST BALTIMORE MD									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 25, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRISON D. KILGORE 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 3 1995		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1108-510
B.K.S




95 06614

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/17/95 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DWAYNE KEARNEY				2. DATE OF DEATH MONTH DAY YEAR MAR. 1 95		3. TIME OF DEATH 1716 P M					
4. SOCIAL SECURITY NUMBER 217-68-0537		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 26, 1958		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) 1208 ENSOR STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH n/a			
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1208 ENSOR STREET				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) G.F.D. -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SORTER		16b. KIND OF BUSINESS/INDUSTRY CITY HOSPITAL					
17. FATHER'S NAME (First, Middle, Last) JAMES B. KEARNEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ernestine j. yarborough							
19a. INFORMANT'S NAME (Type/Print) ERNESTINE J. KEARNEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 ENSOR STREET, BALTIMORE, MARYLAND 21202							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNT AUBURN CEMETERY		DATE 3-7		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC AND COCAINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 3/1/95		28b. TIME OF INJURY 5:10 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1208 ENSOR ST.							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MARCH 2, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06615

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CAROLYN KELLER				2. DATE OF DEATH MONTH FEBRUARY DAY 24 , YEAR 1995		3. TIME OF DEATH 8:15A M	
4. SOCIAL SECURITY NUMBER 215-56-0363		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 16, 52	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MD				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1264 ROSSITER AVENUE			
10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) 2 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNIT CLERK		16b. KIND OF BUSINESS/INDUSTRY GBMC HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) HOWARD KELLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE MAE JACKSON			
19a. INFORMANT'S NAME (Type/Print) VALERIO KELLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 NORTHGATE RD. BALTIMORE, MD. 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cem 3/2/95		20c. LOCATION — City or Town, State Glenburnie md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOOME 1129 N. CAROLINE ST. BALTO, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Retrolental encephalitis DUE TO (OR AS A CONSEQUENCE OF): b. Retrolental infection DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death 1 month 10 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lawrence Gardner MD</i>				29c. LICENSE NUMBER L9693		29d. DATE SIGNED (Month, Day, Year) 2/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lawrence Gardner Tower 110 600 N Wolfe Balt MD 21231							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06616

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna M. Lacher				2. DATE OF DEATH MONTH DAY YEAR Feb. 25. 1995		3. TIME OF DEATH 5:00 P. M.	
4. SOCIAL SECURITY NUMBER 215-03-5752		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 27, 1908	
9a. FACILITY NAME (If not Institution, give street and number) 1706 Belt St.		9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.		9c. COUNTY OF DEATH None		8. BIRTHPLACE (State or Foreign Country) Maryland	
10a. STATE Maryland		10b. COUNTY None		10c. CITY, TOWN OR LOCATION Balto. City, Md.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1706 Belt St.		10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 10th Grade None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George Horner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Bennett			
19a. INFORMANT'S NAME (Type/Print) Mr. Donald H. Lacher				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8440 Garden Rd. Riviera Beach, Md. 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery, 2/28/95		20c. LOCATION — City or Town, State A.A.Co. Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin E. Eche</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest from Ischemic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Hypertensive Arterio Sclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death mins. 10 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Dault M.D.</i>				29c. LICENSE NUMBER D39660		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Dault 707 E. Fort Ave., Baltimore MD 21230							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>Jefi Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06617

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHERINE R. LEEPER				2. DATE OF DEATH MONTH 2 DAY 28 YEAR 95		3. TIME OF DEATH 4:52 p M	
4. SOCIAL SECURITY NUMBER 218-22-3607		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-2-26	
9a. FACILITY NAME (If not institution, give street and number) LORRIEN Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		9c. COUNTY OF DEATH HOWARD			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7003 Hamlet Avenue				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) John Bobrosky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Wolfinger			
19a. INFORMANT'S NAME (Type/Print) Mr. Robert M. Leeper, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 E. West Street Baltimore, Maryland 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 3/4/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard M. Polynick</i>				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Brooklyn 237 East Patapsco Avenue Balto., MD. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart failure. DUE TO (OR AS A CONSEQUENCE OF): Chronic renal failure DUE TO (OR AS A CONSEQUENCE OF): diabetes mellitus. DUE TO (OR AS A CONSEQUENCE OF): ischemic cardiomyopathy. Approximate interval Between Onset and Death years. months years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peripheral vascular disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard M. Polynick</i>				29c. LICENSE NUMBER D31575		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KOLODRUBETZ 9501 Old Annapolis Road Ellicott City MD 21042							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>Julia Driscoll Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06618

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Theodore W. Logan, Jr.				2. DATE OF DEATH MONTH DAY YEAR Feb. 22, 1995		3. TIME OF DEATH 5:30 P.M.	
4. SOCIAL SECURITY NUMBER 215-05-1597		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun. 24, 1913	
9a. FACILITY NAME (If not institution, give street and number) Meridian Long Green				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 607 Lennox Street				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bank Teller		16b. KIND OF BUSINESS/INDUSTRY Banking			
17. FATHER'S NAME (First, Middle, Last) Theodore W. Logan, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lemon Edith Hurd			
19a. INFORMANT'S NAME (Type/Print) Mr. John Dumler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 N. Charles Street, Baltimore, MD 21201			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 2/24		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of S. Baltimore 130 E. Fort Ave., Baltimore 21230			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia b. Multiple Cerebral Vascular Accidents c. d. Approximate Interval Between Onset and Death 1 month Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Fredrick S. Sirkis M.D.				29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 2/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRICK S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John H. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06619

Item# 4.G-film 721 per F.H 3/3/95 P.C

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN LAMKA				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28 1995				3. TIME OF DEATH 11:48 A M	
4. SOCIAL SECURITY NUMBER 214-01-5553		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH City	
10a. STATE MD.				10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Brooklyn	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1322 Cambria Street				10f. ZIP CODE 21225	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shirt Presser				16b. KIND OF BUSINESS/INDUSTRY Laundry				17. FATHER'S NAME (First, Middle, Last) Joseph Karczewski	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Michaleus (unknown)				19a. INFORMANT'S NAME (Type/Print) Lillian Jaskulski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 Hudson Street, Baltimore, Md. 21224	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sc. Ht. of Mary Cemetery 03--3 Baltimore, Md.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen Weber				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester Street, BALTO., Md. 21231				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10 mins 710 yrs > 10 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Jerome Snyder M.D.	
29c. LICENSE NUMBER D22648				29d. DATE SIGNED (Month, Day, Year) 2/28/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerome Snyder M.D. ST. AGNES HOSPITAL BALTO MD 21229	
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06620

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Geraldine Landis				2. DATE OF DEATH MONTH DAY YEAR Feb. 24, 1995		3. TIME OF DEATH 11:20 P.M.	
4. SOCIAL SECURITY NUMBER 236-34-5768		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 13, 1926	
8. BIRTHPLACE (State or Foreign Country) West Virginia		9a. FACILITY NAME (If not institution, give street and number) 7260 Montevideo		9b. CITY, TOWN OR LOCATION OF DEATH Jessup		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 225 Fricks Crossing Road				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Lawrence Mills				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Mayhew			
19a. INFORMANT'S NAME (Type/Print) Kennesaw M. Landis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Fricks Crossing Road, Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Nat'l Memorial Park 2/28		20c. LOCATION — City or Town, State Laurel, Maryland		20d. DATE 2/28	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Head and Neck Carcinoma DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Lung Carcinoma DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD, PhD, DMS				29c. LICENSE NUMBER D 46153		29d. DATE SIGNED (Month, Day, Year) 02/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 06621

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALBERTINE L. LAFOND				2. DATE OF DEATH MONTH DAY YEAR Feb. 28 1995		3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER 820-02-6080		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-7-1904	
9a. FACILITY NAME (If not institution, give street and number) 1504 Groveton Ct.				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Fallston		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1504 Groveton Ct.				10f. ZIP CODE 21047		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Elzier Roy				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) John L. Lafond				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 Groveton Ct. Fallston, Md. 21047			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 3-4 Baltimore, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony Colt Connelly</i>				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death DAYS YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEGENERATIVE JOINT DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. C. Veneracion Jr.</i>				29c. LICENSE NUMBER 513664		29d. DATE SIGNED (Month, Day, Year) 2/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. C. Veneracion Jr., M.D. 1576 Merritt Blvd. Dundalk, Md. 21222							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John L. Lafond</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06622

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) FLORENCE E. MCCOMBS				2. DATE OF DEATH MONTH DAY YEAR MARCH 1, 1995				3. TIME OF DEATH 11:00 p.m.	
4. SOCIAL SECURITY NUMBER 213-26-4672		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 23, 1930		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH A. A. COUNTY	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7935 East Shore Road				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Adjuster			16b. KIND OF BUSINESS/INDUSTRY Social Security Administration				
17. FATHER'S NAME (First, Middle, Last) Clayton Daubert				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Krommes					
19a. INFORMANT'S NAME (Type/Print) Mr. Lane C. Mc Combs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7935 East Shore Road Pasadena, Maryland 21122					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 3/4/95		20c. LOCATION — City or Town, State Glen Burnie, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Glynick</i>				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Stage IV Non Small Cell Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d.								Approximate Interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mayer Gorbaty M.D.</i>				29c. LICENSE NUMBER 027938		29d. DATE SIGNED (Month, Day, Year) 3/2/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAYER GORBATY, M.D. 795 AQUAHART ROAD, #203 GLEN BURNIE, MARYLAND 21061									
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06623

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annie M. Morris				2. DATE OF DEATH MONTH DAY YEAR Feb. 28 95		3. TIME OF DEATH 4.05 AM	
4. SOCIAL SECURITY NUMBER 220-22-6703		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 21, 1927	
8. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Balto		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1910 E. Belvedere Ave				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dietary Aide		16b. KIND OF BUSINESS/INDUSTRY Edenwald Retirement Home			
17. FATHER'S NAME (First, Middle, Last) William Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth			
19a. INFORMANT'S NAME (Type/Print) Karen A. Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 W. Garrison Ave Balto, Md 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Men Park 3/4/95		20c. LOCATION — City or Town, State Randallstown, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Ebron				22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave Balto, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardiorespiratory arrest DUE TO (OR AS A CONSEQUENCE OF):					
		b. Intracranial bleed DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kamalzadeh medical resident				29c. LICENSE NUMBER P08237		29d. DATE SIGNED (Month, Day, Year) Feb. 28.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Kamalzadeh Hassanazadeh Good Samaritan Hospital of Baltimore Maryland 21239							
31. DATE FILED (Month, Day, Year) Feb-28-95				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS WILLIAM MITCHELL				2. DATE OF DEATH MONTH DAY YEAR MAR 01 1995		3. TIME OF DEATH 3:17A	
4. SOCIAL SECURITY NUMBER 220-24-5247		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 23, 1930	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 210 S. GILMORE ST.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.	
9c. COUNTY OF DEATH N/A				10a. STATE Md.			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 210 S. Gilmore St.			
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13-16 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouseman		16b. KIND OF BUSINESS/INDUSTRY Hardware			
17. FATHER'S NAME (First, Middle, Last) William Mitchell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris M. Baggott			
19a. INFORMANT'S NAME (Type/Print) Hugh Mitchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 S. Gilmore St., Balto. Md. 21223			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. LOCATION — City or Town, State Baltimore, Md.		20d. DATE 3/03	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ischemic Abdominal Aneurysm With Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>Ischemic Abdominal Aneurysm With Hemorrhage</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <i>Ischemic Abdominal Aneurysm With Hemorrhage</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. Kaufman</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAR 01 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE MIK 111 Penn Street, Baltimore, Maryland 21201.							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John W. ...</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06625

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LORNA D. MULLEN				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 95		3. TIME OF DEATH 1045P	
4. SOCIAL SECURITY NUMBER 219 105523		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2.11.09	
9a. FACILITY NAME (If not institution, give street and number) TRINITY Geriatric Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 616 N. Kenwood Ave.			
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing Manufacturer	
17. FATHER'S NAME (First, Middle, Last) William O. Staton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Stenson			
19a. INFORMANT'S NAME (Type/Print) Mrs. Linda Jordan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 Allison Ct. BelCamp, Md. 21017			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 3/3		20c. LOCATION — City or Town, State Balto., Md.		20d. DATE 3/3	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David Smith				22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertension, Paroxysmal Atrial Fibrillation c. Dementia d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (Rx) Rt. Atrial. Dislocated Shoulder. ASCD.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER H. Devadoss M.D.				29c. LICENSE NUMBER D-20146		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Devadoss M.D.							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE Julia [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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95 06626

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ronald J. Malecki</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>28</i> YEAR <i>95</i>		3. TIME OF DEATH <i>2:44 P M</i>	
4. SOCIAL SECURITY NUMBER <i>349-20-5270</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 10, 1929</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>n/a</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8005 Windsor Mill Road</i>				10f. ZIP CODE <i>21244</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>Masters Degree</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Systems Anylist</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Social Security Admin.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Joseph C. Malecki</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Harriet Orthman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Elizabeth Malecki</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8005 Windsor Mill Road Baltimore, MD 21244</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Charles Church Cemetery 3/3/95</i>		20c. LOCATION — City or Town, State <i>Pikesville, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Dilated congestive ischemic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>2 years</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Renal Failure</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i>				29c. LICENSE NUMBER <i>P08184</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/20/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George J Hart Mercy Medical Center 201 St Paul Place Baltimore MD 21202</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 03 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

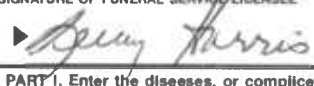

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06627

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JETHRO MARCUS, Sr.				2. DATE OF DEATH MONTH 2 DAY 21 YEAR 95		3. TIME OF DEATH 6:25 PM	
4. SOCIAL SECURITY NUMBER 251-24-2633		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 6, 1926	
8. BIRTHPLACE (State or Foreign Country) S. Carolina				9a. FACILITY NAME (If not institution, give street and number) VA Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2816 Quantico Avenue	
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944 - 1952		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Switch Operator		16b. KIND OF BUSINESS/INDUSTRY Pennsylvania Railroad	
17. FATHER'S NAME (First, Middle, Last) James Marcus, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Kirkland			
19a. INFORMANT'S NAME (Type/Print) James Marcus, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4013 Oakford Avenue Baltimore, Maryland 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Veterans Cem. 2/21/95			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road Chatman-Harris F/H Baltimore, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Cynthia Soriano MD				29c. LICENSE NUMBER P08553		29d. DATE SIGNED (Month, Day, Year) 2/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cynthia Soriano 225 Greene St. Baltimore MD 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CYNTHIA C. MANDELLA				2. DATE OF DEATH MAR 01 1995		3. TIME OF DEATH 12:00 P.M.					
4. SOCIAL SECURITY NUMBER 220-88-3146		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) Set. 29, 1963		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDRICK			9c. COUNTY OF DEATH CALVERT				
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3621 Templar Road				10f. ZIP CODE 21133			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher's Aid			16b. KIND OF BUSINESS/INDUSTRY n/a				
17. FATHER'S NAME (First, Middle, Last) William J. DePuey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn P. Malone							
19a. INFORMANT'S NAME (Type/Print) Carolyn P. DePuey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3621 Templar Rd Randallstown, MD 21133							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park March 6, 1995 Sykesville, MD			20c. LOCATION — City or Town, State						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph J. Kellner				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Roadway									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-1-95		28b. TIME OF INJURY 10-31 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Driver - auto rollover			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Calvert Beach Rd					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER David R Fowler					29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAR 02, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE John D. Kellner									

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

95-0999-510

B.K.S

95 06629

ITEMS: 23 PART I, 27, PER MEU FILM G-721 3/17/95 t.t.
Item #1. G-film 721 per F.H 3/3/95 P.C1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) GARY MELVIN Gary Prentiss Melvin				2. DATE OF DEATH MONTH DAY YEAR FEB. 25 95		3. TIME OF DEATH 1405 P M	
4. SOCIAL SECURITY NUMBER 217-50-1195		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24, 1950	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3220 THE ALAMEDA		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3220 The Alameda	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 yr. College (1-4 or 5+) 1 yr.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Misc. Transfer	
17. FATHER'S NAME (First, Middle, Last) Archie Melvin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorthea McRae			
19a. INFORMANT'S NAME (Type/Print) Fayanna Louise Hodge				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4023 Essex Rd. Baltimore, MD 21207			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/01/95		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dawn F. McDonald</i>				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute M.D.</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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95 06630

Item 31 Film # G 721 3-3-95 N.A. Per funeral Home

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>McCray, Elizabeth</i>				2. DATE OF DEATH MONTH <i>February</i> DAY <i>23</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>5 25</i> M	
4. SOCIAL SECURITY NUMBER <i>214-20-2762</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>03-19-23</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Levinale</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto.</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Pikesville</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3930 Queens Lace Street</i>				10f. ZIP CODE <i>21208</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 years</i> College (1-4 or 5+) <i>Housewife</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Luther Smith</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Geneva Young</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Cynthia Briscoe</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1800 Eloise Lane Edgewood, Maryland 21040</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet. Cem. 3/17/95</i>		20c. LOCATION — City or Town, State <i>Owings Mills, Md</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Henry Harris</i>				22. NAME AND ADDRESS OF FACILITY <i>5240 Reisterstown Road Chatman-Harris F/H Baltimore, Md 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SEPSIS</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Septicemia</i> b. <i>Septicemia</i> c. <i>Septicemia</i> d. <i>Septicemia</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive Cardiovascular Disease</i> <i>Depression; Diabetes</i> <i>Insulin Dependent Diabetes</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard B. Cohen MD</i>				29c. LICENSE NUMBER <i>D21680</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>6717 Poole Heights Avenue 21215</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 03 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1987 1 1 12:00

95-0986-510
ASP

95 06631

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JENNIFER L. McCORMICK				2. DATE OF DEATH MONTH FEB. DAY 25 YEAR 95		3. TIME OF DEATH 4:51 AM					
4. SOCIAL SECURITY NUMBER 219-21-4147		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 15 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 9, 1979		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) MARYLAND SHOCK TRAUMA				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH N/A			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Odenton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1205 Hillcrest Road				10f. ZIP CODE 21113		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Student		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY Education							
17. FATHER'S NAME (First, Middle, Last) Dennis JohnMC CORMICK				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bonnie Gail Schellhase							
19a. INFORMANT'S NAME (Type/Print) Dennis McCormick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Hillcrest Road, Odenton, MD 21113							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 2/27 Baltimore, MD		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patrick J. Smith</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE INJURIES a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 2/24/95		28b. TIME OF INJURY 1800pM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED PEDESTRIAN STRUCK BY AUTO			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROADWAY				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) DAVIDSON ROAD, ANNE ARUNDEL					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald H. Wright MD for</i>						29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 25, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRATION NUMBER <i>John A. Smith</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06632

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IRA I. Mitchell				2. DATE OF DEATH MONTH 02 DAY 27 YEAR 95		3. TIME OF DEATH 10^{PM}	
4. SOCIAL SECURITY NUMBER 116-32-6220		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-02-43	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Mercy Medical center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH NA				10a. STATE MD		10b. COUNTY NA	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1628 N. Calvert Street	
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro American	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Baltimore Public Schools	
17. FATHER'S NAME (First, Middle, Last) IRA E. Mitchell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alicemarie Newsome			
19a. INFORMANT'S NAME (Type/Print) Travis E. Mitchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 14203 Sildell Ct Apt 322 upper, Marlboro			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carolina Biblical Gardens		20c. LOCATION — City or Town, State Raleigh, N.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Miller				22. NAME AND ADDRESS OF FACILITY Jeff Miller Rt 1639 N. Broadway Balto. Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Multiple Organ System Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Staphylococcus Aureus Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Multiple Cerebrovascular Accidents							
DUE TO (OR AS A CONSEQUENCE OF):							
d. Hypertension							
Approximate Interval Between Onset and Death Days							
Approximate Interval Between Onset and Death Days							
Approximate Interval Between Onset and Death months							
Approximate Interval Between Onset and Death years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. First Degree Atrio Ventricular Block							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dwayne BoBo Resident Physician				29c. LICENSE NUMBER P08176		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Decker-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06633

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARRIE L. MOSS				2. DATE OF DEATH MONTH DAY YEAR February 26, 95		3. TIME OF DEATH 7:00 A.M.	
4. SOCIAL SECURITY NUMBER 48-46-0136		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 3, 1936	
9a. FACILITY NAME (If not institution, give street and number) 4635 Chickory Hill Lane				9b. CITY, TOWN OR LOCATION OF DEATH NA		9c. COUNTY OF DEATH BALTO.	
10a. STATE MD				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore County	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 4635 Chickory Hill Lane				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro American	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (13 or 5+) <input checked="" type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) L. B. N.		16b. KIND OF BUSINESS/INDUSTRY Nursing	
17. FATHER'S NAME (First, Middle, Last) Leon Kaiser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Queen E. Stevenson			
19a. INFORMANT'S NAME (Type/Print) Deborah Kaiser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4635 Chickory Hill Lane 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Louisville Cemetery		20c. LOCATION — City or Town, State Louisville, Ky.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Miller				22. NAME AND ADDRESS OF FACILITY Jeff Miller F/H 1639 N. Broadway			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 3 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Marshall A. Lurie				29c. LICENSE NUMBER D17873		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4000 Old Court Rd. Baltimore, MD 21208							
31. DATE FILED (Month, Day, Year) MAR 3 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B.K.S

Item 10e, Film 721, 3/29/95, 1t

ITEMS: 23 PART I, 27, 28a-f, PER MED FILM G-721 3/17/95 t.t

95 06634

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL L. O'DELL				2. DATE OF DEATH MONTH DAY YEAR FEB. 26 95		3. TIME OF DEATH P M 6:06 P M	
4. SOCIAL SECURITY NUMBER 220-70-1939		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 1		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 37		7. DATE OF BIRTH (Month, Day, Year) NOV. 12, 1957	
9a. FACILITY NAME (If not institution, give street and number) 7102 MELSTONE VALLEY ROAD				9b. CITY, TOWN OR LOCATION OF DEATH MARRIOTTSVILLE		9c. COUNTY OF DEATH CARROLL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY CARROLL		10c. CITY, TOWN OR LOCATION MARRIOTTSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7102 MARR MELSTONE VALLEY ROAD				10f. ZIP CODE 21104		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT	
17. FATHER'S NAME (First, Middle, Last) RALPH O'DELL				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVELYN BLEIGH			
19a. INFORMANT'S NAME (Type/Print) STEPHANIE P. O'DELL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12213 SHADETREE LANE, LAUREL, MARYLAND 20708			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CREM 3/1		20c. LOCATION — City or Town, State LAUREL, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENLAFAXINE INTOXICATION AND CUTTING WOUND TO LEFT ARM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND: 2/26/95		28b. TIME OF INJURY 2:49 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED DRUG AND CUT WRIST		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7102 MELSTONE VALLEY RD. MARRIOTTSVILLE, MD.	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HYUNDAI A. KOREAN 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06635

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLOTTE S. POUNDS				2. DATE OF DEATH MONTH DAY YEAR FEB. 28, 1995				3. TIME OF DEATH 8:40 A M			
4. SOCIAL SECURITY NUMBER 218-18-5412		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) AUG. 3, 1920		8. BIRTHPLACE (State or Foreign Country) BALTO., MD	
9a. FACILITY NAME (If not institution, give street and number) ST. MARTIN'S HOME FOR THE AGED				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE				9c. COUNTY OF DEATH BALTIMORE			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 601 MAIDEN CHOICE LANE				10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YEARS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JAMES WALTER SCOTT						18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH J. LONG					
19a. INFORMANT'S NAME (Type/Print) MR. NEWMAN C. POUNDS, JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 DEE JAY DRIVE - ELLICOTT CITY, MD. 21042							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEMETERY 3/3				20c. LOCATION — City or Town, State BALTIMORE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Klug</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>HEPATIC FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CIRRHOSIS LIVER</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 3 day 1 yr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Sambandam Baskaran</i>				29c. LICENSE NUMBER D21649		29d. DATE SIGNED (Month, Day, Year) 2-28-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SAMBANDAM BASKARAN - 3455 WILKENS AVENUE - BALTIMORE, MD 21229											
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John A. Baskaran</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06636

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Doris PRUETT				2. DATE OF DEATH MONTH February DAY 28 YEAR 1995		3. TIME OF DEATH 9:10 am. M	
4. SOCIAL SECURITY NUMBER 217-36-4148		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 17, 1915	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 612 Lanoitan Road				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) Housewife		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY HOUSEWIFE			
17. FATHER'S NAME (First, Middle, Last) Albert T. Mabry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Herenda E. Dickerson			
19a. INFORMANT'S NAME (Type/Print) Doris Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Lanoitan Road Baltimore Md. 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BelAir Memorial 3/3/95		20c. LOCATION — City or Town, State BelAir Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connolly				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis Due to (or as a consequence of): b. Respiratory compromise c. Status post cerebrovascular accident, brainstem d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 days 1 month 1 month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] D.O.				29c. LICENSE NUMBER RD1763		29d. DATE SIGNED (Month, Day, Year) February 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Anthony Campbell D.O. 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) MAR 3 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



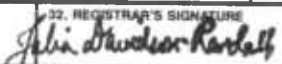
IMPORTANT: If any part of this certificate is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06637

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emma F. Restivo				2. DATE OF DEATH MONTH DAY YEAR Feb. 28, 1995		3. TIME OF DEATH 12:30 p.m.	
4. SOCIAL SECURITY NUMBER 219-14-1003		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 13, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 4 West Randall St.		9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.	
9c. COUNTY OF DEATH None				10a. STATE Maryland		10b. COUNTY None	
10c. CITY, TOWN OR LOCATION Balto. City, Md.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4 West Randall St.	
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 5th. Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) William Hamilton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Bunn			
19a. INFORMANT'S NAME (Type/Print) Mr. Kenneth C. Boblitz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Beech Ave. Balto. Md. 21211			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 3/1/95		20c. LOCATION — City or Town, State Catonsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Av			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest							
b. Secondary to Acute Thrombosis							
c. Hypertensive Cardiovascular Disease							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D27027		29d. DATE SIGNED (Month, Day, Year) 2-28-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1600 S. Charles Street, Baltimore MD 21230							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06638

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lola Raye Rollins</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Feb 24 1995</u>		3. TIME OF DEATH <u>8 AM</u>	
4. SOCIAL SECURITY NUMBER <u>217-58-2203</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 20, 1912</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>2150 Poplar Ridge Road</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Pasadena</u>		9c. COUNTY OF DEATH <u>Anne Arundel</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD</u>		10b. COUNTY <u>Anne Arundel</u>		10c. CITY, TOWN OR LOCATION <u>Pasadena</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>2150 Poplar Ridge Road</u>				10f. ZIP CODE <u>21122</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+) <u>3</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Registered Nurse</u>		15b. KIND OF BUSINESS/INDUSTRY <u>Union Memorial Hospital</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Cicero Alexander Ray</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alzeada Hearn</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Joyce Marsh</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2150 Poplar Ridge Road, Pasadena, MD 21122</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Shiloh Baptist Church Cem. 2/28 King George, VA</u>		20c. LOCATION — City or Town, State <u>VA</u>		20d. DATE <u>2/28</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Steven H. Williams</u>				22. NAME AND ADDRESS OF FACILITY <u>McCully Funeral Home of Pasadena</u> <u>3204 Mountain Road, Pasadena, MD 21122</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Artherosclerotic cardiovascular disease</u>				Approximate interval between Onset and Death <u>Unknown</u>	
		b. <u>Right ventricular failure.</u>				<u>3 years</u>	
		c. <u>Hypertension</u>				<u>7 years</u>	
		d. _____					
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Osteoarthritis</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <u>Julia Ann... Registrar</u>				29c. LICENSE NUMBER <u>D44973</u>		29d. DATE SIGNED (Month, Day, Year) <u>Feb 24 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Gurmeet S. Sawhney, 325 Hospital Drive, Suite 202, MD-21061</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 03 1995</u>		32. REGISTRAR'S SIGNATURE <u>Julia Ann...</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06639

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles W. Smith				2. DATE OF DEATH MONTH DAY YEAR March 1, 1995		3. TIME OF DEATH 4:30 P M	
4. SOCIAL SECURITY NUMBER 218-26-6323		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 16, 1930	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2116 Willow Spring Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Dundalk	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Dundalk			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2116 Willow Spring Rd.			
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Line Worker		16. KIND OF BUSINESS/INDUSTRY Automobile			
17. FATHER'S NAME (First, Middle, Last) Charles W. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Marie Mercen			
19a. INFORMANT'S NAME (Type/Print) Deborah David				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 230th Street, Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Mem. Pk. Mar. 4, '95		20c. LOCATION — City or Town, State Glen Burnie, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E., Glen Burnie, MD 21061			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan O'Donovan, M.D.				29c. LICENSE NUMBER DO 7632		29d. DATE SIGNED (Month, Day, Year) March 3, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. J. Crossan O'Donovan, 2112 Dundalk Ave., Baltimore, Maryland 21222							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06640

Item# 17.G-film 721 per F.H 3/3/95 P.C

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ollie W. Smith				2. DATE OF DEATH MONTH MARCH DAY 01 YEAR 1995		3. TIME OF DEATH 4:00 am .M	
4. SOCIAL SECURITY NUMBER 125-12-3360		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-21-15	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5512 WOODMONT AVE				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) HENRY SMITH Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN SMITH			
19a. INFORMANT'S NAME (Type/Print) MATTIE SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5512 WOODMONT AVE BALTIMORE, MD. 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Med. 3/6/95 Towson, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):							
b. SEPSIS DUE TO (OR AS A CONSEQUENCE OF):							
c. MULTIPLE MYELOMA DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death 2 days 10 days 2 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancytopenia							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural 5. <input type="checkbox"/> Pending Investigation 2. <input type="checkbox"/> Accident 6. <input type="checkbox"/> Could not be determined 3. <input type="checkbox"/> Suicide 6. <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. (Medical Resident)				29c. LICENSE NUMBER P 08049		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASAD, FARHANA 201 E UNIV. PKWAY BALTIMORE MD 21218.							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06641

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Joseph Scannell				2. DATE OF DEATH MONTH DAY YEAR February 27 1995		3. TIME OF DEATH 9:17 AM	
4. SOCIAL SECURITY NUMBER 221-34-5159		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1946	
9a. FACILITY NAME (If not institution, give street and number) FAUSTON General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH FAUSTON		9c. COUNTY OF DEATH HARFORD	
10a. STATE MARYLAND		10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1307 ST. FRANCIS ROAD				10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 4 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES		16b. KIND OF BUSINESS/INDUSTRY Envirocon			
17. FATHER'S NAME (First, Middle, Last) LEONARD FRANCIS Scannell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vivian A. HAYNES			
19a. INFORMANT'S NAME (Type/Print) JUDITH H. Scannell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 ST. FRANCIS ROAD Bel Air, Maryland 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MARY'S CHURCH CEMETERY 3-23		20c. LOCATION — City or Town, State PYKEVILLE MARYLAND		22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - BEL AIR, PA. 3 NEWPORT DRIVE FOREST HILL MO. 64080	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - BEL AIR, PA. 3 NEWPORT DRIVE FOREST HILL MO. 64080			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gram negative bacterial Septic Shock 12 hours DUE TO (OR AS A CONSEQUENCE OF): b. gastrointestinal bleeding 24 hours DUE TO (OR AS A CONSEQUENCE OF): c. esophageal varices 2 years DUE TO (OR AS A CONSEQUENCE OF): d. liver cirrhosis 2 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D36715		29d. DATE SIGNED (Month, Day, Year) February 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHERIF OSMAN, MD 504 Lewis Street Havre De Grace, MD 21078							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06642

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carroll Winfield SHAY				2. DATE OF DEATH MONTH DAY YEAR March 1, 1995		3. TIME OF DEATH 5:26 P M	
4. SOCIAL SECURITY NUMBER 220 24 2061		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 20, 1930	
8a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital Center				8b. CITY, TOWN OR LOCATION OF DEATH Rossville		8c. COUNTY OF DEATH Baltimore	
9a. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Middle River	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2221 Vailthorne Road		10f. ZIP CODE 21220	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1948 - 1969	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Serviceman				16b. KIND OF BUSINESS/INDUSTRY U.S. Navy			
17. FATHER'S NAME (First, Middle, Last) John E. Shay				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Hayes			
19a. INFORMANT'S NAME (Type/Print) Michael R. Shay				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1921 Blacks School House Rd. Westminster, Md 21158			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 3/3/1995		20c. LOCATION — City or Town, State Baltimore City, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Md 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>mitral regurgitation</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley Z. Gekberg MD</i>				29c. LICENSE NUMBER 001080		29d. DATE SIGNED (Month, Day, Year) March 2, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stanley Z. Gekberg MD 11 E. Chase St 21202</i>							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>Richard Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06643

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN MARIE SMITH				2. DATE OF DEATH MONTH MARCH DAY 2 YEAR 1995		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 218-01-1192		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 12, 1910	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH BALTIMORE CITY			
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 2001 WHISTLER AVENUE			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) H/S GRAD		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING			
17. FATHER'S NAME (First, Middle, Last) (UNKNOWN) OREM				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) LOUIS E. SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1385 UNIONTOWN ROAD - WESTMINSTER, MD 21158			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 3/4		20c. LOCATION — City or Town, State ELKRIDGE		21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]	
22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE,,MD 21229		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dehydration DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 days 4 days					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Raafat X. Girgis				29c. LICENSE NUMBER D31762		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Raafat X. Girgis - St. Agnes Hospital							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) MORRIS ANTHONY SMITH				2. DATE OF DEATH MONTH DAY YEAR MARCH 01, 1995		3. TIME OF DEATH 17:45 P M	
4. SOCIAL SECURITY NUMBER 215-12-7304		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) FEB. 12, 1922		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not Institution, give street and number) 2001 WHISTLER AVE.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2001 WHISTLER AVENUE				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH GRADE College (1-4 or 5+) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) G TRUCK DRIVER		15b. KIND OF BUSINESS/INDUSTRY DORN'S TRANSPORTATION			
17. FATHER'S NAME (First, Middle, Last) CHARLES SMITH				16. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE (UNKNOWN)			
19a. INFORMANT'S NAME (Type/Print) LOUIS E. SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1385 UNIONTOWN ROAD - WESTMINSTER, MD. 21158			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 03/4		DATE ELKRIDGE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie D. Shannon</i>		22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) MARCH 02, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

95 06645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCIS GEORGE SINDALL, Jr.				2. DATE OF DEATH MONTH DAY YEAR FEB 28 1995		3. TIME OF DEATH 9:23 P.M.	
4. SOCIAL SECURITY NUMBER 220-07-1686		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 28, 1918	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION TIMONIUM		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 16 Bandon Court, Unit 302				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Advertising			
17. FATHER'S NAME (First, Middle, Last) Francis G. Sindall, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Sabina Jimenez			
19a. INFORMANT'S NAME (Type/Print) Frances Sindall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Bandon Court, Unit 302, Timonium, MD 21093			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. MAR 4		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lowell M. Lemmon				22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death 2 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner				29c. LICENSE NUMBER D05643		29d. DATE SIGNED (Month, Day, Year) 3/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Davidson Radell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06646

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHANE ADAM SAVAGE				2. DATE OF DEATH MONTH DAY YEAR Feb 28, 1995		3. TIME OF DEATH 2 A. M	
4. SOCIAL SECURITY NUMBER 218-64-8157		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 3, 1960	
9a. FACILITY NAME (If not institution, give street and number) 21 Ashmill Court				9b. CITY, TOWN OR LOCATION OF DEATH Whitemarsh		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Whitemarsh	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 21 Ashmill Court				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Funeral Director		16b. KIND OF BUSINESS/INDUSTRY Funeral			
17. FATHER'S NAME (First, Middle, Last) P. Dean Savage				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gloria Yommer			
19a. INFORMANT'S NAME (Type/Print) Ronald J. Kroha				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Ashmill Court, Baltimore, Maryland 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery		DATE 04 Mar		20c. LOCATION — City or Town, State Pikesville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary				22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cardiac arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>hypoxemia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 5-7 days 2 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Human Immunodeficiency Virus</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard A. Berg, M.D.				29c. LICENSE NUMBER 020604		29d. DATE SIGNED (Month, Day, Year) March 2, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard A. Berg, M.D. 4000 Old Court Road, Suite 306, Pikesville, MD 21208							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John A. Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06647

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY C. SIEMIANOWSKI				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 95		3. TIME OF DEATH 10:45 AM	
4. SOCIAL SECURITY NUMBER 169-03-2171		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 12, 1902	
8. BIRTHPLACE (State or Foreign Country) Natrona, Pa.		9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Pa.			
10b. COUNTY West Moreland				10c. CITY, TOWN OR LOCATION New Kensington			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1200 Leishman Ave.			
10f. ZIP CODE 15068				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian		16b. KIND OF BUSINESS/INDUSTRY Public School District	
17. FATHER'S NAME (First, Middle, Last) Frank Lewandowski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kulik			
19a. INFORMANT'S NAME (Type/Print) Evelyn C. Kolton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2153 Copley Drive Pensacola, Florida 23503			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, chapel, or other place) St. Marys Cemetery Mar. 4, 95		20c. LOCATION — City or Town, State Lower Burrell, Pa.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Eline</i>	
22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, Md. 21136				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD b. Multiple Infarcts - CVA c. advanced age d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Dutton MD</i>		29c. LICENSE NUMBER D25483	
29d. DATE SIGNED (Month, Day, Year) 3/1/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 688 Poole Road Westminster, Md 21158			
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>John M. Dutton</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06648

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Norman John Sickels				2. DATE OF DEATH MONTH March DAY 1 YEAR 1995		3. TIME OF DEATH 1:56 AM	
4. SOCIAL SECURITY NUMBER 166-09-4451		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 22, 1908	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Phoenix		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13712 Summer Hill Drive				10f. ZIP CODE 21131		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII, Korean Conflict		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marketing		16b. KIND OF BUSINESS/INDUSTRY Fuel Industry	
17. FATHER'S NAME (First, Middle, Last) Norman John Sickels, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Mitchell			
19a. INFORMANT'S NAME (Type/Print) Betty Hanna Sickels				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13712 Summer Hill Drive, Phoenix, MD 21131			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of institution, crematory, or other place) Metro Crematory, Inc. 03/03/95		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute infero-lateral wall myocardial infarction 6-8 hours							
b. Severe anemia 3 days							
c. Hemorrhagic chronic inflammatory bowel disease years							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Howard L. Siegel, M.D.				29c. LICENSE NUMBER D28885		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard L. Siegel, M.D. GBMC 6701 N. Charles Street Baltimore, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995				32. REGISTRAR'S SIGNATURE Julia Shuler-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06649

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) DEAN C. SOMMERS				2. DATE OF DEATH MONTH Feb. DAY 26 YEAR 1995		3. TIME OF DEATH 3:45pm M	
4. SOCIAL SECURITY NUMBER 217-14-3234		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1922	
8. BIRTHPLACE (State or Foreign Country) Balt. Md.				9a. FACILITY NAME (If not institution, give street and number) 705 Orchard Overlook # 103		9b. CITY, TOWN OR LOCATION OF DEATH Odenton	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Md.		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Odenton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 705 Orchard Overlook # 103	
10f. ZIP CODE 21113				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Service Manager			
16. KIND OF BUSINESS/INDUSTRY Automobile				17. FATHER'S NAME (First, Middle, Last) Charles Allen Sommers			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Dean Powell Myers				19a. INFORMANT'S NAME (Type/Print) Clara A. Sommers			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Orchard Overlook #103 Odenton Md. 21113				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Cemetery				20c. LOCATION — City or Town, State 3-1 Davidsonville Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A. 851 Annapolis Rd. Gambrills MD. 21054			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. CHF DUE TO (OR AS A CONSEQUENCE OF):							
b. CAD DUE TO (OR AS A CONSEQUENCE OF):							
c. CRF DUE TO (OR AS A CONSEQUENCE OF):							
d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D36761		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. R. R. 2568 Rova Rd Annap							
31. DATE FILED (Month, Day, Year) MAR 1 1995							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06650

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS J. THOMMEN, SR.				2. DATE OF DEATH MONTH DAY YEAR MARCH 1, 1995		3. TIME OF DEATH 1:17 p.m.	
4. SOCIAL SECURITY NUMBER 705-05-5992		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar. 19, 1903	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A. A. COUNTY	
10a. STATE Maryland				10b. COUNTY None		10c. CITY, TOWN OR LOCATION Balto. City, Md.	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1420 Riverside Ave.			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th. Grade		15b. COLLEGE (1-4 or 5+) None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Record		16b. KIND OF BUSINESS/INDUSTRY B.O. Railroad	
17. FATHER'S NAME (First, Middle, Last) William Francis Thommen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Agnes Reilly			
19a. INFORMANT'S NAME (Type/Print) Mr. John E. Thommen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7875 Kavanagh Rd. Balto. Md. 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemt. 3/4/95		20c. LOCATION — City or Town, State A.A. Co. Md.		20d. DATE DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Thommen</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. INTRACTABLE CONGESTIVE HEART FAILURE							2 wks.
b. RENAL FAILURE							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIGOXIN TOXICITY ELECTROLYTE IMBALANCE							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attena</i>				29c. LICENSE NUMBER D 21776		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURYA P. MUNDRA, M.D. 1600 CRAIN HIGHWAY, SW, #106 GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) MAR 4 3 1995				32. REGISTRAR'S SIGNATURE <i>John E. Thommen</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06651

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES W. THOMPSON				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 25, 1995		3. TIME OF DEATH 8:40 P M	
4. SOCIAL SECURITY NUMBER 349-26-9018		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 15, 1935	
8. BIRTHPLACE (State or Foreign Country) Wisconsin				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH M/A				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1 Deer Pass Court	
10f. ZIP CODE 21030				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 8 YRS.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PSYCHOLOGIST		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE COUNTY BOARD OF EDUCATION	
17. FATHER'S NAME (First, Middle, Last) BERT A. THOMPSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY DAVE			
19a. INFORMANT'S NAME (Type/Print) DAVID S. THOMPSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3224 SPINNAKER POINT FOREST, VIRGINIA 24551			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 2-25-95		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVAN CHAPLAIN OF CHIMES 2325 YORK ROAD - TIMONIUM			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → hypoglycemia							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): metabolic acidosis 7 days							
b. DUE TO (OR AS A CONSEQUENCE OF): infection 7 days							
c. DUE TO (OR AS A CONSEQUENCE OF): renal cell carcinoma, metastatic 3 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R. Brachmann M.D.				29c. LICENSE NUMBER L0372		29d. DATE SIGNED (Month, Day, Year) 2/25/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rainer Brachmann Johns Hopkins Onc. Center Baltimore							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06652

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Telp				2. DATE OF DEATH MONTH 2 DAY 25 YEAR 95		3. TIME OF DEATH 0900A	
4. SOCIAL SECURITY NUMBER 215-24-3734		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) 07-13-22		8. BIRTHPLACE (State or Foreign Country) PA	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5102 ELMER AVENUE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLES SKYES				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA ROBINSON			
19a. INFORMANT'S NAME (Type/Print) JOSA MAY ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 YALE AVE BALTIMORE, MD. 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CE 3/3		20c. LOCATION — City or Town, State OWINGS MILLS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE LIVER DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER AS 240-2324 P9759		29d. DATE SIGNED (Month, Day, Year) 2/25/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER P. PARK, MD Sinai Hospital							
31. DATE FILED (Month, Day, Year) MAR 6 3 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06653

ITEM: 18. PER F.H. FILM G-721 3/14/95 t.t.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth G. Thurston				2. DATE OF DEATH MONTH FEB. DAY 28 YEAR 1995		3. TIME OF DEATH 12:55 P M	
4. SOCIAL SECURITY NUMBER 211-12-6525		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 12, 1921	
9a. FACILITY NAME (If not institution, give street and number) 10028 Crane Lane				9b. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10028 Crane Lane				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Key Punch Operator		16b. KIND OF BUSINESS/INDUSTRY Steel Mill			
17. FATHER'S NAME (First, Middle, Last) Dorsey A. Griffith				18. MOTHER'S NAME (First, Middle, Maiden Surname) May Shaffer MARY SHAFFER			
19a. INFORMANT'S NAME (Type/Print) Franklin J. Thurston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10028 Crane Lane Baltimore, MD 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Bel Air Memorial Gardens		DATE 3/3/95		20c. LOCATION — City or Town, State Bel Air, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P. A. 1407 Eastern Ave. Baltimore, MD 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. BREAST CANCER WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER H41069		29d. DATE SIGNED (Month, Day, Year) 3-1-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1308 Business Ch Way # 102 Edgewood, MD 21040							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first thing I noticed when I stepped
out of the plane was the fresh air. It felt like
I had been in a bubble for hours. The sun was
shining brightly, and the birds were singing.
I took a deep breath and felt a sense of
peace. I had finally reached my destination.
The hotel was beautiful, and the staff was
friendly. I was in luck. I had found a
great place to stay. I was going to have a
great trip. I was going to have a great
time. I was going to have a great
experience. I was going to have a great
memory. I was going to have a great
time. I was going to have a great
experience. I was going to have a great
memory.

95-0993-510
DWG

UNK 95-072

95 06654

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/17/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELLIS VAUGHN III				2. DATE OF DEATH MONTH DAY YEAR FEB. 25 95		3. TIME OF DEATH 0930A M							
4. SOCIAL SECURITY NUMBER 241-56-2533		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-21-41		8. BIRTHPLACE (State or Foreign Country) N.C.					
9a. FACILITY NAME (If not institution, give street and number) FRONTING 1413 N. WOLFE STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A						
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10a. STREET AND NUMBER 213 N. DUNCAN ST.				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER			16b. KIND OF BUSINESS/INDUSTRY INDUSTRY								
17. FATHER'S NAME (First, Middle, Last) ELLIS VAUGHN II				18. MOTHER'S NAME (First, Middle, Maiden Surname) LIZZIE PERRY									
19a. INFORMANT'S NAME (Type/Print) ANNIE VAUGHN JACKSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 N. POTOMAC ST. BALTIMORE, MD. 21213									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		OATE 3/3		20c. LOCATION — City or Town, State LANSDOWNE, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George Cronan</i>				22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD 21213									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPOTHERMIA ASSOCIATED WITH ETHANOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SIDEWALK											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 2-25-95		28b. TIME OF INJURY FOUND 9:31 AM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED HYPOTHERMIA EXPOSURE					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND ON STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1400 BLK. N. WOLFE ST. BALTIMORE, MARYLAND									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Devin J. Chute MD</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB. 26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201													
31. DATE SIGNED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>											

BALTIMORE, MARYLAND 21215-0020
DIVISION OF VITAL RECORDS, P.O. BOX 68760TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06655

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emmaline Williams				2. DATE OF DEATH MONTH Mar. DAY 1 YEAR 1995		3. TIME OF DEATH 1:20 A M	
4. SOCIAL SECURITY NUMBER 227-30-9517		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 9, 1919	
9a. FACILITY NAME (If not institution, give street and number) Levindale Geriatric				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 740 Poplar Grove St.			
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic Worker Outside of Home		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Thaddeus Cockrell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Flowers			
19a. INFORMANT'S NAME (Type/Print) Vernell Hair				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 W. Franklin St. Balto. Md. 21223			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Western Star 3/4/95 Balto. Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ				22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fungemia							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Debra S Wertheimer MD				29c. LICENSE NUMBER D23767		29d. DATE SIGNED (Month, Day, Year) March 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEBRA S WERTHEIMER MD 2434 W. Belvedere Ave. Balto, MD 21215							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE John Andrew Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06656

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVERETT Allen WHEELER				2. DATE OF DEATH MONTH FEBRUARY DAY 23 YEAR 1995				3. TIME OF DEATH 5:54 P M	
4. SOCIAL SECURITY NUMBER 225-18-9120		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) June 17, 1921				8. BIRTHPLACE (State or Foreign Country) VIRGINIA					
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Md				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Glen Arm			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 12802 MANOR Rd.				10f. ZIP CODE 21057				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY UNION LOCAL 24					
17. FATHER'S NAME (First, Middle, Last) FONZA CLARKE Wheeler				18. MOTHER'S NAME (First, Middle, Maiden Surname) PAULINE CROSSWHITE					
19a. INFORMANT'S NAME (Type/Print) Glennice W. Wheeler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12802 MANOR Rd Glen Arm, Md. 21057					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview U. Meth Church Cem		DATE 2/27/95		20c. LOCATION — City or Town, State Jacksonville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Graves</i>				22. NAME AND ADDRESS OF FACILITY EVANS Chapel of Chimes 2325 York Rd. Timonium, Md. 21093					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death 1/2 hr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Schams</i>				29c. LICENSE NUMBER D 31976		29d. DATE SIGNED (Month, Day, Year) 2/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID SCHAMS MD 201 E. UNIVERSITY PKWY BALTIMORE MD 21218									
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06657

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY B. WILSON				2. DATE OF DEATH MONTH MARCH DAY 2 YEAR 1995		3. TIME OF DEATH 1230 P.M.	
4. SOCIAL SECURITY NUMBER 215-24-5826		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 13, 1899	
9a. FACILITY NAME (If not institution, give street and number) LONGVIEW NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH MANCHESTER		9c. COUNTY OF DEATH CARROLL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1939 GRIFFIS AVENUE				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH GRADE College (1-4 or 5+) HOMEMAKER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING			
17. FATHER'S NAME (First, Middle, Last) MEREAN N. WHEELER				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA LEE O'CONNOR			
19a. INFORMANT'S NAME (Type/Print) ALBERT HIERSTETTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 OLD WESTMINSTER PIKE - WESTMINSTER, MD 21157			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) TRINITY CHURCH CEMETERY 3/5		20c. LOCATION — City or Town, State HOWARD COUNTY			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
a. DUE TO (OR AS A CONSEQUENCE OF): Cellulitis rt leg -							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia Peripheral Vascular Disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W H Soard MD				29c. LICENSE NUMBER D02386		29d. DATE SIGNED (Month, Day, Year) 3/2/1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. W. H. SOARD - 3223 MAIN STREET - MANCHESTER, MD							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06658

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ZACK WARD, JR.				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 95		3. TIME OF DEATH 4:10p M	
4. SOCIAL SECURITY NUMBER 246-30-8351		5. SEX MALE <input type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-31-26	
8a. FACILITY NAME (If not institution, give street and number) 2434 Barclay St.				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH n/a	
9. RESIDENCE OF DECEDENT				10a. STATE MD		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2434 Barclay St.				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 16+) 2yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Postal Service			
17. FATHER'S NAME (First, Middle, Last) Zack Ward, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laurel Daniels			
19a. INFORMANT'S NAME (Type/Print) Inez E. Ward				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2434 Barclay St. Balto., MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest 3/5		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Homes 1701 Laurens St. Balto., Md 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Prostate Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 18 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paraplegia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Davis M. Hahn</i>				29c. LICENSE NUMBER D20396		29d. DATE SIGNED (Month, Day, Year) 3/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Davis M. Hahn 5601 Loch Raven Blvd Balto Md 21237							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE <i>Julia...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28a is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

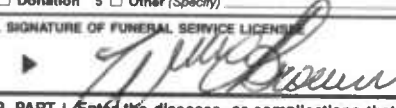


1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JAMES ROBERT WILEY				2. DATE OF DEATH MONTH DAY YEAR FEB 25 95		3. TIME OF DEATH 3:41 P.M.	
4. SOCIAL SECURITY NUMBER 217-26-6341		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-16-1919	
9a. FACILITY NAME (If not institution, give street and number) SINAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH NA	
10a. STATE MARYLAND		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3624 W. BELVEDERE AVENUE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BECTION DICKINSON LAB		16b. KIND OF BUSINESS/INDUSTRY NA			
17. FATHER'S NAME (First, Middle, Last) JOHN R. WILEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGURITA WILEY			
19a. INFORMANT'S NAME (Type/Print) Novella Savage				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 N. Monroe St. Baltimore, Maryland 21217			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville Veteran 3/2		20c. LOCATION — City or Town, State Crownsville, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY William C. Brown Community F/H 1206 W. North Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INQUIRY
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Dennis Chute M.D.				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) FEB 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 03 1995		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vivian A. Wilson				2. DATE OF DEATH MONTH DAY YEAR MARCH 01 1995		3. TIME OF DEATH 0620 AM	
4. SOCIAL SECURITY NUMBER 212-18-5943		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-21-1918	
8a. FACILITY NAME (If not institution, give street and number) DEATON MEDICAL CEENTER				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		8c. COUNTY OF DEATH MARYLAND	
9a. RESIDENCE OF DECEDENT 10a. STATE MD.				10b. COUNTY WIA		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 611 S. Charles street			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC, RAILROAD		16b. KIND OF BUSINESS/INDUSTRY Wk			
17. FATHER'S NAME (First, Middle, Last) JAMES J. WILSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN BROWN			
19a. INFORMANT'S NAME (Type/Print) LOIS R. PATTERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 WEST CONWAY ST. APT. 906 BALTO.MD. 21201			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, etc.) MT. ZION CEMETERY 03-04-95		20c. LOCATION — City or Town, State LANSDOWNE, MD.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H P.A. 638 N. GILMORE STREET @!@ 21217		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. hypertension DUE TO (OR AS A CONSEQUENCE OF): b. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death Yrs months yrs					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Azotemic, S/PDVT S/PCHA				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D28998		29d. DATE SIGNED (Month, Day, Year) 3-2-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRITHAM S SAMI 9101 Cherry LN # 211 Laurel MD 20708							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

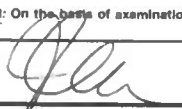
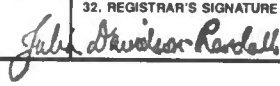
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06661

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN P. ZEBELEAN, JR.				2. DATE OF DEATH MONTH DAY YEAR Feb. 28 1995		3. TIME OF DEATH 10:50 A. M.	
4. SOCIAL SECURITY NUMBER 219-03-2720		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 12, 1914	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE CITY				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION CATONSVILLE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 5605 WILKENS AVENUE	
10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) COLLEGE GRAD		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAWYER & JUDGE		16b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED			
17. FATHER'S NAME (First, Middle, Last) JOHN ZEBELEAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSA BURA			
19a. INFORMANT'S NAME (Type/Print) LT.COL. JOHN P. ZEBELEAN, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 WILKENS AVENUE - CATONSVILLE, MD 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 3/3		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS a. DUE TO (OR AS A CONSEQUENCE OF): ENDOCARDITIS b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease, Significant Mitral Regurgitation Prostate Cancer DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30802		29d. DATE SIGNED (Month, Day, Year) Feb. 29, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jean M. Colandrea, M.D., St. Agnes Hospital - 900 Caton Avenue, Baltimore, Md. 21229							
31. DATE FILED (Month, Day, Year) MAR 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06662

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Matthew Henry Aeschleman				2. DATE OF DEATH MONTH DAY YEAR February 16, 1995		3. TIME OF DEATH 9:05 A M	
4. SOCIAL SECURITY NUMBER 222-38-7486		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 24, 1958	
8. BIRTHPLACE (State or Foreign Country) Wisconsin				9a. FACILITY NAME (If not institution, give street and number) 102 Esperanza Terrace		9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Lexington Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 102 Esperanza Terrace	
10f. ZIP CODE 20653				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Consultant		16b. KIND OF BUSINESS/INDUSTRY Technical Consultant Company			
17. FATHER'S NAME (First, Middle, Last) Edward Alvin Aeschleman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Carol Sauder			
19a. INFORMANT'S NAME (Type/Print) Jill Aeschleman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Esperanza Terrace, Lexington Park, MD 20653			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Apostolic Christian Cemetery 2-22-95		20c. LOCATION — City or Town, State Lester, Iowa		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward N. Brinsfield, Jr. M00052	
22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic lymphoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death 5 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Charles Bennett M.D.		29c. LICENSE NUMBER D25156	
29d. DATE SIGNED (Month, Day, Year) 2-17-95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Bennett, M.D. 11845 H G Trueman Road, Lusby, Maryland 20657			
31. DATE FILED (Month, Day, Year) FEB 17 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06663

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH RAY ADCOCK				2. DATE OF DEATH MONTH FEB DAY 11 YEAR 1995		3. TIME OF DEATH 11:10 A M	
4. SOCIAL SECURITY NUMBER 306-30-7053		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 6, 1933	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Delaware				10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Dover	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 75 Delshire Drive			
10f. ZIP CODE 19901				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Master Sergeant		16b. KIND OF BUSINESS/INDUSTRY U.S. Air Force	
17. FATHER'S NAME (First, Middle, Last) Willie Miles Adcock				18. MOTHER'S NAME (First, Middle, Maiden Surname) Adella Louisa			
19a. INFORMANT'S NAME (Type/Print) Celida Adcock				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Delshire Drive - Dover, DE 19901			
20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Delaware Veterans Memorial Ceme. 2/17/95		20c. LOCATION — City or Town, State Bear, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William C. Galt</i>				22. NAME AND ADDRESS OF FACILITY Torbert Funeral Chapel 61 S. Bradford St. - Dover, DE 19904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Gilstad</i>				29c. LICENSE NUMBER 848532		29d. DATE SIGNED (Month, Day, Year) Feb 15 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. GILSTAD, LT, MC, USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600							
31. DATE FILED (Month, Day, Year) FEB 17 '95				32. REGISTRAR'S SIGNATURE <i>F. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06664

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK DAVIS ALLISON				2. DATE OF DEATH MONTH FEB DAY 09 YEAR 95		3. TIME OF DEATH 2:29 p.m.	
4. SOCIAL SECURITY NUMBER 228-20-3474		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 26, 1926	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1803 Amherst Road				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Traffic Manager		16b. KIND OF BUSINESS/INDUSTRY Retail			
17. FATHER'S NAME (First, Middle, Last) Robert Davis Allison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel (NMN) Lipsey			
19a. INFORMANT'S NAME (Type/Print) Virginia Lee Allison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1803 Amherst Road, Hyattsville, Maryland 20783			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 02/13/95		20c. LOCATION — City or Town, State Brentwood, Maryland		22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Green</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>immediate</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):				long-standing	
		c. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF):				long-standing	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Diabetes</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D21435			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Ketting MD</i>				29d. DATE SIGNED (Month, Day, Year) 3/9/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul Ketting MD 2101 Medical Park Dr Silver Spring, Md 20902</i>							
31. DATE FILED (Month, Day, Year) FEB 14 1995				32. REGISTRAR'S SIGNATURE <i>John A. Harkett</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 06665

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES AQUILINO				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1995		3. TIME OF DEATH 10:25 P M	
4. SOCIAL SECURITY NUMBER 578-01-1363		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 14, 1911	
8. BIRTHPLACE (State or Foreign Country) Washington, DC		9a. FACILITY NAME (If not institution, give street and number) Glady's Spellman Nursing H.		9b. CITY/TOWN OR LOCATION OF DEATH Ches.		9c. COUNTY OF DEATH P.C.	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12309 Rockledge Drive				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. Army WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY R.E.A.			
17. FATHER'S NAME (First, Middle, Last) Joseph Auilino				18. MOTHER'S NAME (First, Middle, Maiden Surname) Enfante Lucy			
19a. INFORMANT'S NAME (Type/Print) Michael Aquilino				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12309 Rockledge Drive, Bowie, MD 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery		DATE 2/15/95		20c. LOCATION — City or Town, State Suitland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia with Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Louis Steinberg MD</i>				29c. LICENSE NUMBER D12015		29d. DATE SIGNED (Month, Day, Year) 2-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Steinberg 6492 Landover Rd Landover MD 20785							
31. DATE FILED (Month, Day, Year) FEB 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06666

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARION ELSIE ARMSTRONG				2. DATE OF DEATH MONTH 2 DAY 11 YEAR 95		3. TIME OF DEATH 1256 P^M	
4. SOCIAL SECURITY NUMBER 220-10-8672		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar 5, 1917	
9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER		9c. COUNTY OF DEATH CARROLL	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Finksburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2972 Bloom Road				10f. ZIP CODE 21048		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Robert G. Short				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. (Walls)			
19a. INFORMANT'S NAME (Type/Print) Carroll E. Armstrong				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2972 Bloom Road; Finksburg, MD 21048			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		DATE 02/15		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cardiopulmonary failure DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Metastatic lymphoma DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John A. Steers MD				29c. LICENSE NUMBER MD #D44614		29d. DATE SIGNED (Month/Day/Year) 2/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Steers MD 542 Washington Rd Westminster MD 21157							
31. DATE OF DEATH (Month/Day/Year) FEB 15 1995				32. REGISTRAR'S SIGNATURE John A. Steers			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06667

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charles Ayers</i>				2. DATE OF DEATH MONTH DAY YEAR Feb 23, 1995		3. TIME OF DEATH 9:00 a.m.	
4. SOCIAL SECURITY NUMBER 222 - 18 - 5543		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 5, 1931	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 607 Loch Haven Road			
9b. CITY, TOWN OR LOCATION OF DEATH Edgewater				9c. COUNTY OF DEATH Anne Arundel			
10a. STATE Florida		10b. COUNTY Volusia		10c. CITY, TOWN OR LOCATION Pierson		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1704 Harper Road				10f. ZIP CODE 32180		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pile Driver		16b. KIND OF BUSINESS/INDUSTRY Bridge Construction	
17. FATHER'S NAME (First, Middle, Last) Charles W. Ayers, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elenora Mae Hart			
19a. INFORMANT'S NAME (Type/Print) Denise Messineo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Loch Haven Road, Edgewater, Maryland 21037			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 2/23		20c. LOCATION — City or Town, State Catonsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>circulation of the liver</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 4 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D31188		29d. DATE SIGNED (Month, Day, Year) 2/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 Ridgely Ave. Annapolis, Md 21401 R COLLAN							
31. DATE FILED (Month, Day, Year) FEB 24 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

1. The first part of the document is a list of names and addresses of the members of the committee. The names are listed in alphabetical order, and the addresses are given below each name. The list is as follows:

Name	Address
Mr. A. B. C.	123 Main St., New York, N. Y.
Mr. D. E. F.	456 Broadway, New York, N. Y.
Mr. G. H. I.	789 Fifth Ave., New York, N. Y.
Mr. J. K. L.	1010 Third Ave., New York, N. Y.
Mr. M. N. O.	1111 Second Ave., New York, N. Y.
Mr. P. Q. R.	1212 First Ave., New York, N. Y.
Mr. S. T. U.	1313 West 125th St., New York, N. Y.
Mr. V. W. X.	1414 East 125th St., New York, N. Y.
Mr. Y. Z. A.	1515 Central Ave., New York, N. Y.
Mr. B. C. D.	1616 Union Ave., New York, N. Y.
Mr. E. F. G.	1717 Madison Ave., New York, N. Y.
Mr. H. I. J.	1818 Park Ave., New York, N. Y.
Mr. K. L. M.	1919 Lexington Ave., New York, N. Y.
Mr. N. O. P.	2020 Fifth Ave., New York, N. Y.
Mr. Q. R. S.	2121 Third Ave., New York, N. Y.
Mr. T. U. V.	2222 Second Ave., New York, N. Y.
Mr. W. X. Y.	2323 First Ave., New York, N. Y.
Mr. Z. A. B.	2424 West 125th St., New York, N. Y.
Mr. C. D. E.	2525 East 125th St., New York, N. Y.
Mr. F. G. H.	2626 Central Ave., New York, N. Y.
Mr. I. J. K.	2727 Union Ave., New York, N. Y.
Mr. L. M. N.	2828 Madison Ave., New York, N. Y.
Mr. O. P. Q.	2929 Park Ave., New York, N. Y.
Mr. R. S. T.	3030 Lexington Ave., New York, N. Y.
Mr. U. V. W.	3131 Fifth Ave., New York, N. Y.
Mr. X. Y. Z.	3232 Third Ave., New York, N. Y.
Mr. A. B. C.	3333 Second Ave., New York, N. Y.
Mr. D. E. F.	3434 First Ave., New York, N. Y.
Mr. G. H. I.	3535 West 125th St., New York, N. Y.
Mr. J. K. L.	3636 East 125th St., New York, N. Y.
Mr. M. N. O.	3737 Central Ave., New York, N. Y.
Mr. P. Q. R.	3838 Union Ave., New York, N. Y.
Mr. S. T. U.	3939 Madison Ave., New York, N. Y.
Mr. V. W. X.	4040 Park Ave., New York, N. Y.
Mr. Y. Z. A.	4141 Lexington Ave., New York, N. Y.
Mr. B. C. D.	4242 Fifth Ave., New York, N. Y.
Mr. E. F. G.	4343 Third Ave., New York, N. Y.
Mr. H. I. J.	4444 Second Ave., New York, N. Y.
Mr. K. L. M.	4545 First Ave., New York, N. Y.
Mr. N. O. P.	4646 West 125th St., New York, N. Y.
Mr. Q. R. S.	4747 East 125th St., New York, N. Y.
Mr. T. U. V.	4848 Central Ave., New York, N. Y.
Mr. W. X. Y.	4949 Union Ave., New York, N. Y.
Mr. Z. A. B.	5050 Madison Ave., New York, N. Y.
Mr. C. D. E.	5151 Park Ave., New York, N. Y.
Mr. F. G. H.	5252 Lexington Ave., New York, N. Y.
Mr. I. J. K.	5353 Fifth Ave., New York, N. Y.
Mr. L. M. N.	5454 Third Ave., New York, N. Y.
Mr. O. P. Q.	5555 Second Ave., New York, N. Y.
Mr. R. S. T.	5656 First Ave., New York, N. Y.
Mr. U. V. W.	5757 West 125th St., New York, N. Y.
Mr. X. Y. Z.	5858 East 125th St., New York, N. Y.
Mr. A. B. C.	5959 Central Ave., New York, N. Y.
Mr. D. E. F.	6060 Union Ave., New York, N. Y.
Mr. G. H. I.	6161 Madison Ave., New York, N. Y.
Mr. J. K. L.	6262 Park Ave., New York, N. Y.
Mr. M. N. O.	6363 Lexington Ave., New York, N. Y.
Mr. P. Q. R.	6464 Fifth Ave., New York, N. Y.
Mr. S. T. U.	6565 Third Ave., New York, N. Y.
Mr. V. W. X.	6666 Second Ave., New York, N. Y.
Mr. Y. Z. A.	6767 First Ave., New York, N. Y.
Mr. B. C. D.	6868 West 125th St., New York, N. Y.
Mr. E. F. G.	6969 East 125th St., New York, N. Y.
Mr. H. I. J.	7070 Central Ave., New York, N. Y.
Mr. K. L. M.	7171 Union Ave., New York, N. Y.
Mr. N. O. P.	7272 Madison Ave., New York, N. Y.
Mr. Q. R. S.	7373 Park Ave., New York, N. Y.
Mr. T. U. V.	7474 Lexington Ave., New York, N. Y.
Mr. W. X. Y.	7575 Fifth Ave., New York, N. Y.
Mr. Z. A. B.	7676 Third Ave., New York, N. Y.
Mr. C. D. E.	7777 Second Ave., New York, N. Y.
Mr. F. G. H.	7878 First Ave., New York, N. Y.
Mr. I. J. K.	7979 West 125th St., New York, N. Y.
Mr. L. M. N.	8080 East 125th St., New York, N. Y.
Mr. O. P. Q.	8181 Central Ave., New York, N. Y.
Mr. R. S. T.	8282 Union Ave., New York, N. Y.
Mr. U. V. W.	8383 Madison Ave., New York, N. Y.
Mr. X. Y. Z.	8484 Park Ave., New York, N. Y.
Mr. A. B. C.	8585 Lexington Ave., New York, N. Y.
Mr. D. E. F.	8686 Fifth Ave., New York, N. Y.
Mr. G. H. I.	8787 Third Ave., New York, N. Y.
Mr. J. K. L.	8888 Second Ave., New York, N. Y.
Mr. M. N. O.	8989 First Ave., New York, N. Y.
Mr. P. Q. R.	9090 West 125th St., New York, N. Y.
Mr. S. T. U.	9191 East 125th St., New York, N. Y.
Mr. V. W. X.	9292 Central Ave., New York, N. Y.
Mr. Y. Z. A.	9393 Union Ave., New York, N. Y.
Mr. B. C. D.	9494 Madison Ave., New York, N. Y.
Mr. E. F. G.	9595 Park Ave., New York, N. Y.
Mr. H. I. J.	9696 Lexington Ave., New York, N. Y.
Mr. K. L. M.	9797 Fifth Ave., New York, N. Y.
Mr. N. O. P.	9898 Third Ave., New York, N. Y.
Mr. Q. R. S.	9999 Second Ave., New York, N. Y.
Mr. T. U. V.	10000 First Ave., New York, N. Y.

2. The second part of the document is a list of names and addresses of the members of the committee. The names are listed in alphabetical order, and the addresses are given below each name. The list is as follows:

Name	Address
Mr. A. B. C.	123 Main St., New York, N. Y.
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Mr. J. K. L.	1010 Third Ave., New York, N. Y.
Mr. M. N. O.	1111 Second Ave., New York, N. Y.
Mr. P. Q. R.	1212 First Ave., New York, N. Y.
Mr. S. T. U.	1313 West 125th St., New York, N. Y.
Mr. V. W. X.	1414 East 125th St., New York, N. Y.
Mr. Y. Z. A.	1515 Central Ave., New York, N. Y.
Mr. B. C. D.	1616 Union Ave., New York, N. Y.
Mr. E. F. G.	1717 Madison Ave., New York, N. Y.
Mr. H. I. J.	1818 Park Ave., New York, N. Y.
Mr. K. L. M.	1919 Lexington Ave., New York, N. Y.
Mr. N. O. P.	2020 Fifth Ave., New York, N. Y.
Mr. Q. R. S.	2121 Third Ave., New York, N. Y.
Mr. T. U. V.	2222 Second Ave., New York, N. Y.
Mr. W. X. Y.	2323 First Ave., New York, N. Y.
Mr. Z. A. B.	2424 West 125th St., New York, N. Y.
Mr. C. D. E.	2525 East 125th St., New York, N. Y.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Daphne Allen</u>				2. DATE OF DEATH MONTH DAY YEAR <u>February 18 1995</u>		3. TIME OF DEATH <u>07:39 P.</u>	
4. SOCIAL SECURITY NUMBER <u>416-28-3367</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>75</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>April 20, 1919</u>	
8. BIRTHPLACE (State or Foreign Country) <u>SC</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Physicians Memorial Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>LaPlata</u>		9c. COUNTY OF DEATH <u>Charles</u>	
10a. STATE <u>MD</u>		10b. COUNTY <u>Charles</u>		10c. CITY, TOWN OR LOCATION <u>LaPlata</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>8701 Mitchell Rd.</u>				10f. ZIP CODE <u>20646</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u>6</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>School Teacher</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Education</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Amos Carter Allen</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Eola Powell Allen</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Xuripha Allen Curto</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8701 Mitchell Rd. LaPlata, MD 20646</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) <u>New Live Oak Cem. 2/22/95</u>		20c. LOCATION — City or Town, State <u>Selma, Alabama</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>David C. Echols</u> MO0945				22. NAME AND ADDRESS OF FACILITY <u>AREHART-ECHOLS FUNERAL HOME, INC.</u> <u>P.O. Box 567 LaPlata, MD 20646</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sudden cardiac death</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Hypertension and</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Dyslipidemia</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Polycystic gammopathy</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>B. Larry Jenkins</u>				29c. LICENSE NUMBER <u>D-33426</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/19/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>B. Larry Jenkins MD 111 LaGrange Ave. PO Box 1724 LaPlata Md. 20646</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 21 1995</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06669

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Julius Lee Allen, Sr.				2. DATE OF DEATH February 13, 1995				3. TIME OF DEATH 7:00 A.			
4. SOCIAL SECURITY NUMBER 250-44-8713		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	7. DATE OF BIRTH June 12, 1932		8. BIRTHPLACE (State or Foreign Country) South Carolina					
9a. FACILITY NAME (If not institution, give street and number) 109 Pates Drive				9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington			9c. COUNTY OF DEATH Prince George's				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Fort Washington			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 109 Pates Drive				10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marketing Specialist		16b. KIND OF BUSINESS/INDUSTRY G.S.A. (Federal Government)							
17. FATHER'S NAME (First, Middle, Last) Luther B. Allen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jenny Rosemond							
19a. INFORMANT'S NAME (Type/Print) Mrs. Helen Jean Allen (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Pates Drive Fort Washington, Maryland 20744							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Maryland Veterans Cemetery		DATE 2/17/95		20c. LOCATION — City or Town, State Cheltenham, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janet C. Anderson</i>				22. NAME AND ADDRESS OF FACILITY Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pharyngeal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold Mirsky</i>				29c. LICENSE NUMBER DC5244		29d. DATE SIGNED (Month, Day, Year) February 15, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harold Mirsky, M.D. 730 24th Street, N.W. Suite #7 Washington, D.C.											
31. DATE FILED (Month, Day, Year) FEB 16 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06670

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY A. ANGOTTA				2. DATE OF DEATH MONTH DAY YEAR February 14, 1995		3. TIME OF DEATH 11:52 P M	
4. SOCIAL SECURITY NUMBER 093-09-0217		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 18, 1916	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) V.A. Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland			
10b. COUNTY Cecil				10c. CITY, TOWN OR LOCATION Perryville			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 549 Aiken Avenue			
10f. ZIP CODE 21903				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Five Years College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Robbins Door & Sash Company Johnson City, New York	
17. FATHER'S NAME (First, Middle, Last) Louis Peter Angotta				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cleo Santos			
19a. INFORMANT'S NAME (Type/Print) Beatrice L. Angotta				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 549 Aiken Avenue, Perryville, Maryland 21903			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Vestal Hill Memorial Cemetery 2/20/95		20c. LOCATION — City or Town, State Binghamton, New York		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard Freeman Sr.</i>	
22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Freeman</i>				29c. LICENSE NUMBER D37065		29d. DATE SIGNED (Month, Day, Year) 2/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD FREEMAN, M.D., VA Medical Center, Perry Point, MD 21902							
31. DATE FILED FEB 16 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06671

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rosa Lee Wilson Buga				2. DATE OF DEATH MONTH February DAY 7 YEAR 1995		3. TIME OF DEATH 0720 M	
4. SOCIAL SECURITY NUMBER 228-42-6854		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-01-34	
8. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE VA		10b. COUNTY Accomack		10c. CITY, TOWN OR LOCATION New Church		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 32041 Chincoteague				10f. ZIP CODE 23415		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Persey Wilson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie ?			
19a. INFORMANT'S NAME (Type/Print) C.P. Wilson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24459 Nanticoke Rd Quantico, Md.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Tabernacle BAPT CH. Rt 1/2 Thornton, VA.		20c. LOCATION — City or Town, State Thornton, VA.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Keith E. Wharton				22. NAME AND ADDRESS OF FACILITY WHARTON F/H 22171 WHARTON RD. Accomack, VA.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Urosepsis a. DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Christion Huddleston				29c. LICENSE NUMBER 029105		29d. DATE SIGNED (Month, Day, Year) 2/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christion Huddleston, M.D. 106 Milford St., Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) FEB 16 1995				32. REGISTRAR'S SIGNATURE John Wilson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06672

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hilda Wade Briscoe				2. DATE OF DEATH MONTH February DAY 15, YEAR 1995		3. TIME OF DEATH 11:50 P.M.	
4. SOCIAL SECURITY NUMBER 217-46-6423		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 21, 1899	
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn		9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland				10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Hollywood	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER Rt. 3 Box 568				10f. ZIP CODE 20636		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) John T. Maddox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Adriana C. Gough			
19a. INFORMANT'S NAME (Type/Print) John H. Briscoe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 Box 568, Hollywood, MD 20636			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Aloysius Cemetery 2/18/95		20c. LOCATION — City or Town, State Leonardtwn, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary Failure</i> b. <i>Sepsis</i> c. d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>days</i> <i>wk</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i> <i>Peripheral Vascular Disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <i>N.A.</i>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe, M.D.</i>				29c. LICENSE NUMBER <i>D 06419</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-17-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) <i>FEB 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>John A. Harrison</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06673

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Francis Bryant				2. DATE OF DEATH MONTH DAY YEAR February 14, 1995		3. TIME OF DEATH 12:20p. M	
4. SOCIAL SECURITY NUMBER 216-40-6736		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 20, 1913	
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtown		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Colton's Point		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 42				10f. ZIP CODE 20626		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4 or 5+)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		18b. KIND OF BUSINESS/INDUSTRY Seafood	
17. FATHER'S NAME (First, Middle, Last) William McDonald Bryant				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Ann Russell			
19a. INFORMANT'S NAME (Type/Print) Joseph L. Bryant				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 42, Colton's Point, Maryland 20626			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart Cemetery 2/17/1995		20c. LOCATION — City or Town, State Bushwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cardiopulmonary Failure</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>min</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Cardiac Arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>min</i>	
		c. <i>Coronary Artery DE</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>yes</i>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Muscular Dystrophy</i> <i>Congestive Heart Failure</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. Patrick Jarboe, M.D.</i>				29c. LICENSE NUMBER 006419		29d. DATE SIGNED (Month, Day, Year) 2-15-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) FEB 17 1995				32. REGISTRAR'S SIGNATURE <i>Julia Ann Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0581-037
B.K.S

95 06674

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS JARRETT BALLARD				2. DATE OF DEATH MONTH DAY YEAR FEB. 2 95		3. TIME OF DEATH 1400 P M							
4. SOCIAL SECURITY NUMBER 218-19-4232		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 4, 1979		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 70 ANDERSON LANE				9b. CITY, TOWN OR LOCATION OF DEATH MECHANICSVILLE			9c. COUNTY OF DEATH ST. MARY'S						
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Charlotte Hall			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER Rt. 1 Box 445-A Rollins Lane				10f. ZIP CODE 20622		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farm Hand		16. KIND OF BUSINESS/INDUSTRY Farm									
17. FATHER'S NAME (First, Middle, Last) Bradley Lee Ballard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Ellen Jarrett									
19a. INFORMANT'S NAME (Type/Print) Bradley Lee Ballard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 445-A Rollins Ln, Charlotte Hall, Md 20622									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hertzler Cemetery 2/4/95		20c. LOCATION — City or Town, State Mechanicsville, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Contact Shotgun Wound of Head</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) YARD		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 2-2-95		28b. TIME OF INJURY UNK M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Subject shot self</i>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. L. A. Locke MD</i>		29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) FEB. 3, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. L. A. Locke, MD 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) FEB 07 1995				32. REGISTRAR'S SIGNATURE <i>J. L. A. Locke</i>									

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06675

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ralph Bailey				2. DATE OF DEATH MONTH January DAY 30 , YEAR 1995		3. TIME OF DEATH 8:00 a.m.	
4. SOCIAL SECURITY NUMBER 138-22-7941		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1927	
9a. FACILITY NAME (If not institution, give street and number) 105 Pine Needle Court				9b. CITY, TOWN OR LOCATION OF DEATH California		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION California		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 105 Pine Needle Court				10f. ZIP CODE 20619		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1949-1967		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Defense			
17. FATHER'S NAME (First, Middle, Last) Hampton Bailey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Evans			
19a. INFORMANT'S NAME (Type/Print) Mattie M. Bailey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Pine Needle Court, California, Maryland 20619			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 2-6-95		20c. LOCATION — City or Town, State Arlington, Virginia		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr., M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardio infarction							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Arteriosclerosis heart disease							
c. Diabetes mellitus							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John B. Tourtelot</i> John Tourtelot, M.D., Naval Hospital, Patuxent River, Maryland 20670				29c. LICENSE NUMBER 035346		29d. DATE SIGNED (Month, Day, Year) 1-30-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tourtelot, M.D., Naval Hospital, Patuxent River, Maryland 20670							
31. DATE FILED (Month, Day, Year) FEB 01 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06676

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SADIE RUTH BEACH				2. DATE OF DEATH MONTH DAY YEAR Feb. 13, 1995		3. TIME OF DEATH HOURS MIN. SEC. 3:35 A M		
4. SOCIAL SECURITY NUMBER 222-09-4335		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-30-1896		
9a. FACILITY NAME (If not institution, give street and number) Salisbury Nursing & Rehab Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, Md.		9c. COUNTY OF DEATH WICOMICO		
10a. STATE Md.		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 200 Civic Ave.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner Grocery Store		18b. KIND OF BUSINESS/INDUSTRY Country Grocery Store				
17. FATHER'S NAME (First, Middle, Last) Sherman Owens				16. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Donoho Owens				
19a. INFORMANT'S NAME (Type/Print) Bobby O. Beach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Richwill Dr. Salisbury, Md. 21801				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Firemen's Cemetery		DATE 2-15		20c. LOCATION — City or Town, State Sharptown, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> a. <i>Hypertension</i> b. <i>Coronary Artery Disease</i> c. <i>Diabetes Mellitus</i> d. <i>Chronic Kidney Disease</i> </div> <div> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): </div> </div>							Approximate Interval Between Onset and Death <i>5 years</i> <i>15 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED				
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Robins, M.D.</i>		29c. LICENSE NUMBER 029749		29d. DATE SIGNED (Month, Day, Year) 2/13/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. 21801								
31. DATE FILED (Month, Day, Year) FEB 14 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>						

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06677

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vilhelm Bjerknes				2. DATE OF DEATH MONTH DAY YEAR Feb. 12 1995		3. TIME OF DEATH 10:00 AM M	
4. SOCIAL SECURITY NUMBER 557 48 9379		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 13, 1931	
9a. FACILITY NAME (If not institution, give street and number) 12205 Wheeling Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 12205 Wheeling Ave.			
10f. ZIP CODE 20772				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meteorologist		16b. KIND OF BUSINESS/INDUSTRY National Weather Service			
17. FATHER'S NAME (First, Middle, Last) Jacob Bjerknes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hedvig Borthen			
19a. INFORMANT'S NAME (Type/Print) Inger Bjerknes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12205 Wheeling Ave. Upper Marlboro Md. 20772			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		20c. LOCATION — City or Town, State Davidsonville Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Carcinoma of the Lung</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE OF INJURY			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James H. Paveran</i>				29c. LICENSE NUMBER MD 708694		29d. DATE SIGNED (Month, Day, Year) 2/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) FEB 15 1995				32. REGISTRAR'S SIGNATURE <i>James H. Paveran</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06678

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Noreen W. Bigelow				2. DATE OF DEATH MONTH DAY YEAR Feb. 9, 1995		3. TIME OF DEATH 6:17 P.M. M	
4. SOCIAL SECURITY NUMBER 579 56 5779		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 30, 1942	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania		9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2421 Kinderbrook Lane		10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Paul Welling				18. MOTHER'S NAME (First, Middle, Maiden Surname) Twila Lint			
19a. INFORMANT'S NAME (Type/Print) Kenneth J. Bigelow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2421 Kinderbrook Lane Bowie Maryland 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Memorial Gardens 2/13/95		20c. LOCATION — City or Town, State Davidsonville Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Glioma DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER Dennis R. Schumaker MD				29b. LICENSE NUMBER D15666		29c. DATE SIGNED (Month, Day, Year) 2/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis R. Schumaker MD 14204 COURBET PARK DR #102 LAUREL MD 20706							
31. DATE FILED (Month, Day, Year) FEB 15 1995				32. REGISTRAR'S SIGNATURE Janet Davidson-Wardall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06679

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Violet Memery Barnes				2. DATE OF DEATH MONTH DAY YEAR Feb 17 1995		3. TIME OF DEATH 10:10A M	
4. SOCIAL SECURITY NUMBER 025-36-3335		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 6 1907	
9a. FACILITY NAME (If not institution, give street and number) LIONS MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1000 CAMDEN AVE.				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher		16b. KIND OF BUSINESS/INDUSTRY School Teacher			
17. FATHER'S NAME (First, Middle, Last) JAMES MEMERY				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE STOKES			
19a. INFORMANT'S NAME (Type/Print) PAMELA M. GRAZIO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 CAMDEN AVE. CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY FEB 17 1995		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure; aortic aneurysm of the abdomen, Alzheimers							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i>				29c. LICENSE NUMBER D09157		29d. DATE SIGNED (Month, Day, Year) FEB 17 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D., Lions Manor N.H., Seton Dr., Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) FEB 17 1995				32. REGISTRAR'S SIGNATURE <i>J. Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

X

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

95 06680

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|---|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)
FLORENCE LORRAINE BUCKEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11, 1995 | | 3. TIME OF DEATH
5:30 P M | |
| 4. SOCIAL SECURITY NUMBER
705-10-4810 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
95 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Dec 5, 1899 | 8. BIRTHPLACE (State or Foreign Country)
MD | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Oldtown | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Route 1 Box 21 | | | | 10f. ZIP CODE
21555 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)
12
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Telegraph Operator | | 16b. KIND OF BUSINESS/INDUSTRY
Railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas M. Ginevan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carrie V. Runkle | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robin Schaidt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
943 Maryland Avenue; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Oldtown Cemetery | | 20c. DATE
02/13 | | 20d. LOCATION — City or Town, State
Oldtown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James J. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
A.S.C.V.D.

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
24 hrs
15 Y's |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
at. fib. (new onset), C.H.F., HTN. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
2/11/95 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>C. Vincent M.D.</i> | | | | 29c. LICENSE NUMBER
D17474 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Clarence Vincent, M.D. 909-B Seton Drive Cumberland MD 21502 | | | | | | | |
| 31. DATE (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06681

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Eileen Bridget Brady</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>February 17, 1995</i> | | 3. TIME OF DEATH
M
<i>1:02P</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>103 - 12 - 6850</i> | | 5. SEX
<i>1 M 2 F</i> | 6. AGE (In yrs. last birthday)
<i>85</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)
<i>July 14, 1909</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Ireland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Doctor's Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Lanham</i> | | 9c. COUNTY OF DEATH
<i>Prince George</i> | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>Prince George</i> | | 10c. CITY, TOWN OR LOCATION
<i>Greensbelt</i> | |
| 10d. INSIDE CITY LIMITS?
<i>1 X YES 2 NO</i> | | | | 10e. STREET AND NUMBER
<i>7010 Greenbelt Road</i> | | 10f. ZIP CODE
<i>20770</i> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 11. MARITAL STATUS
<i>1 X Never Married 2 Married 3 Widowed 4 Divorced</i> | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i>
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<i>1 YES 2 NO</i> Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<i>Grade 7</i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Housewife</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Own Home</i> | | 17. FATHER'S NAME (First, Middle, Last)
<i>Francis Fahey</i> | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Sarah O'Brien</i> | | | | 19a. INFORMANT'S NAME (Type/Print)
<i>Helen Kennedy</i> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>19205 Mt. Airey Road, Brookeville, Maryland 20833</i> | |
| 20a. METHOD OF DISPOSITION
<i>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Lorraine Park</i> | | 20c. LOCATION — City or Town, State
<i>2/21 Woodlawn, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration PNEUMONITIS</i>
DUE TO (OR AS A CONSEQUENCE OF): <i>Recurrent</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>① Massive Pleural Effusion, right
② Atelectasis of Lung - right</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<i>1 YES 2 X NO</i> | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<i>1 YES 2 NO</i> | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<i>1 YES 2 X NO</i> | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <i>1 X Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> | | | | | |
| 27. MANNER OF DEATH
<i>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i> | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<i>1 YES 2 NO</i> | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<i>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>
<i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mohammed A. Mannan MD</i> | | | | 29c. LICENSE NUMBER
<i>D24593</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2-17-95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
<i>MOHAMMED A. MANNAN MD, 3715 - RHODE ISLAND AVE MOUNT RAINIER, MD 20712</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 2 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06682

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHIRLEY VIRGINIA BEALL | | | | 2. DATE OF DEATH
MONTH February DAY 17 YEAR 1995 | | 3. TIME OF DEATH
10:20 a m | |
| 4. SOCIAL SECURITY NUMBER
214 - 18 - 8981 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
June 20, 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Laurel Regional Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | 9c. COUNTY OF DEATH
Prince George | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Laurel | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9547 Linville Avenue | | | | 10f. ZIP CODE
20723 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 12
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Medical Practice | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter Shipe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret Merson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Penny Klages | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1406 Brenwoode Road, Annapolis, Maryland 21401 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Meadowridge Memorial Park 2/20 | | 20c. LOCATION — City or Town, State
Dorsey, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Louise Dannehan</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death
5 minutes
Acute Incident | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent Diabetes Mellitus | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William A. Warren MD</i> | | | | 29c. LICENSE NUMBER
D13916 | | 29d. DATE SIGNED (Month, Day, Year)
2/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William A. Warren 321 Prince George St Laurel 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


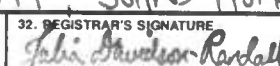
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NEWBORN BOND
NEWBORN BOND
NEWBORN BOND

95 06683

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
KENNETH, R. BALLIET | | | | 2. DATE OF DEATH
MONTH 02 / DAY 18 / YEAR 1995 | | 3. TIME OF DEATH
23:26 M | |
| 4. SOCIAL SECURITY NUMBER
143-32-6046 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
54 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
07/18/1940 | |
| 9a. FACILITY NAME (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Belcamp | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1415 Sedum Square | | | | 10f. ZIP CODE
21017 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Raymond Harry Balliet | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen Halama | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Karen D. Balliet | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1415 Sedum Square, Belcamp, MD 21017 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
R. A. Ferris & Co., Inc. 2/20 | | 20c. LOCATION — City or Town, State
West Chester, PA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Mitchell-Smith Funeral Home, P.A.
Havre de Grace, MD 21078-3197 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRA-ABDOMINAL HEMORRHAGE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. ORTHO TOPIC LIVER TRANSPLANT | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. SCLEROSING CHOLANGITIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ULCERATIVE COLITIS; HYPERTENSION | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
P. CHEVRAY MD/PHD | | | | 29c. LICENSE NUMBER
M 1314 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PIERRE CHEVRAY, JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06684

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ruth Bowman Baublitz | | | | 2. DATE OF DEATH
February 19 1995 | | 3. TIME OF DEATH
2:15 P M | |
| 4. SOCIAL SECURITY NUMBER
175-10-1026 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
08-05-1909 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9. FACILITY NAME (If not institution, give street and number)
Physicians Memorial Hospital | | 10. CITY, TOWN OR LOCATION OF DEATH
LaPlata | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY OF DEATH
Charles | | 13. STATE
Maryland | |
| 14. 10a. STATE
Maryland | | 15. 10b. COUNTY
Charles | | 16. 10c. CITY, TOWN OR LOCATION
White Plains | | 17. 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 18. 10e. STREET AND NUMBER
10469 Willetts Crossing Road | | | | 19. 10f. ZIP CODE
20695 | | 20. 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 21. 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 22. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 23. 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 24. 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 25. 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12)
8 | | 26. 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Supervisor | | 27. 16b. KIND OF BUSINESS/INDUSTRY
Dental Industry | | | |
| 28. 17. FATHER'S NAME (First, Middle, Last)
Charles Bowman | | | | 29. 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bessie Luckenbaugh Bowman | | | |
| 30. 19a. INFORMANT'S NAME (Type/Print)
Roland W. Zeigler | | | | 31. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10469 Willetts Crossing Road White Plains, MD 20695 | | | |
| 32. 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 33. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greenmount Cemetery 2-23-95 | | 34. 20c. LOCATION — City or Town, State
York, PA 17404 | | | |
| 35. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John A. Zeigler</i> M00173 | | | | 36. 22. NAME AND ADDRESS OF FACILITY
J.H. Eberwein Mortuary
4433 White Pls La White Pls., MD 20695 | | | |
| 37. 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Vascular Accident</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
<i>Renal Failure</i>
<i>Adverse Effects of Aspirin</i> | | | | | | 38. Approximate Interval Between Onset and Death | |
| 39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 40. 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 41. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 42. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 43. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 44. 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 45. 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 46. 28a. DATE OF INJURY (Month, Day, Year) | | 47. 28b. TIME OF INJURY
M | | 48. 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 49. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 50. 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 51. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 52. 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 53. 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>George H. Wathen</i> | | | | 54. 29c. LICENSE NUMBER
D-20629 | | 55. 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 56. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
George H. Wathen, MD 11345 Rembrooke Square Suite 104 Waldorf MD 20603 | | | | 57. 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | |
| 58. 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson Randall</i> | | | | 59. 33. DATE OF DEATH
FEB 19 1995 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET A BAILEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 13, 1995 | | 3. TIME OF DEATH
8:20 P M | |
| 4. SOCIAL SECURITY NUMBER
9415 293-01-9085 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
98 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 14, 1896 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Pineview Manor Extended Care | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Clinton | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9415 Cheltenham Ave., | | | | 10f. ZIP CODE
20735 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Liscensed Pratical Nurse | | 16b. KIND OF BUSINESS/INDUSTRY
Private Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
A.C. Burr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Stella G. Doolittle | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Elizabeth W. Bailey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9415 Cheltenham Ave, Clinton, Md 20735 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lee Crematory Feb 15, 1995 | | 20c. LOCATION — City or Town, State
Clinton, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
HK S. Smith | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc 6633 Old Alexander Ferry Road Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Small Bowel obstruction | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Urinary Tract infection | | | | | | | |
| c. PARKINSON disease | | | | | | | |
| d. Dementia | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
gastro intestinal Bleed. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
K. Samac m.d. | | | | 29c. LICENSE NUMBER
D 25640 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KHOSROW DAVACHI M.D. 1328 SOUTHERN AVE WASHINGTON, D.C. 20032 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Rodall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06686

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles W. Banks, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 17 1995 | | 3. TIME OF DEATH
15:38 M | |
| 4. SOCIAL SECURITY NUMBER
218-20-8634 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 6, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Dorchester General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cambridge | | 9c. COUNTY OF DEATH
Dorchester | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Dorchester | | 10c. CITY, TOWN OR LOCATION
Cambridge | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2149 Horns Point Road | | | |
| 10f. ZIP CODE
21613 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1945-1954 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
Grade 11 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
maintennance mechanic | | 16b. KIND OF BUSINESS/INDUSTRY
City Housing Authority | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles W. Banks, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elsie Mae Nichols | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Pauline Virginia Banks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2149 Horns Point Road Cambridge, Maryland | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Veterans Cemetery | | 20c. LOCATION — City or Town, State
2/22 Hurlock, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Janelle C. Henry | |
| 22. NAME AND ADDRESS OF FACILITY
Henry Funeral Home
510 Washington St. Cambridge, Maryland | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Hypertensive Cardiovascular Disease
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael Joyce MD | | | | 29c. LICENSE NUMBER
D31730 | | 29d. DATE SIGNED (Month, Day, Year)
2-21-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael Joyce, MD 300 Byrn Street Cambridge, MD 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06687

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Alice Lorraine Bergen | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 18, 1995 | | 3. TIME OF DEATH
6:45 P M | |
| 4. SOCIAL SECURITY NUMBER
579-03-5337 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept 21 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number)
9110 Erie Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
North Beach | | 9c. COUNTY OF DEATH
Calvert | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
North Beach | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9110 Erie Avenue | | | | 10f. ZIP CODE
20714 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Book Bindery Operator | | 16b. KIND OF BUSINESS/INDUSTRY
US Gov't Printing Office | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Brandenburg | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice Meadows | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rosalie Russell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 634 North Beach MD 20714 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 2-21-95 | | 20c. LOCATION — City or Town, State
Suitland, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home, PA Owings, MD 20736 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung — Undifferentiated Bronchogenic Carcinoma 1 month
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease/Arteriosclerosis
Aortic Valve Stenosis / Hypertension | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Gerald P. Steiner MD | | | | 29c. LICENSE NUMBER
D17245 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 20, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
(MAGGIE) Maggie M. Berman | | | | 2. DATE OF DEATH
MONTH Feb DAY 10 YEAR 1995 | | 3. TIME OF DEATH
2:00AM M | |
| 4. SOCIAL SECURITY NUMBER
221-22-2105 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-12-1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
Crisfield, MD | | | | 9a. FACILITY NAME (If not institution, give street and number)
Culvert Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rising Sun, MD | |
| 9c. COUNTY OF DEATH
Cecil | | | | 10a. STATE
Maryland | | 10b. COUNTY
Cecil | |
| 10c. CITY, TOWN OR LOCATION
Rising Sun | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1881 Telegraph Road | |
| 10f. ZIP CODE
21911 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Merchant | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Gordon Means | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minahg Sterling | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Julius L. Berman - Son | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
309 Ashbourne Rd, Claymont, DE 19703 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Silverbrook Cemetery | | 20c. LOCATION — City or Town, State
Wilmington, DE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ala... | | | | 22. NAME AND ADDRESS OF FACILITY
Schoenbay Memorial Chapel
579 Phila. Pike, Wilmington, DE 19809 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute congestive heart failure
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cancer Rectum - (Carcinoma of Rectum)
c. Cancer Lung
d. Seizure disorder secondary Metastasis
Approximate interval Between Onset and Death
5-days
1993
1979- | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
NONE | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Jayantilal K. Patel MD | | | | 29c. LICENSE NUMBER
022307 | | 29d. DATE SIGNED (Month, Day, Year)
2/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAYANTILAL K. PATEL MD - 123 SINGERLY AVE, ELKTON MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06689

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anna Marie Cannon | | | | 2. DATE OF DEATH
MONTH 2 DAY 14 YEAR 95 | | 3. TIME OF DEATH
16:30 M | |
| 4. SOCIAL SECURITY NUMBER
217-22-7693 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/27/14 | |
| 8. BIRTHPLACE (State or Foreign Country)
MD | | | | 9. FACILITY NAME (If not institution, give street and number)
1570 Teal Dr. | | 10. CITY, TOWN OR LOCATION OF DEATH
Ocean City | |
| 11. COUNTY OF DEATH
Worcester | | | | 12. RESIDENCE OF DECEDENT
10a. STATE MD 10b. COUNTY Worcester | | 13. 10c. CITY, TOWN OR LOCATION
Ocean City | |
| 14. 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 15. 10e. STREET AND NUMBER
1570 Teal Dr. | | 16. 10f. ZIP CODE
21842 | |
| 17. 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | 18. 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 19. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 20. 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 21. 14. RACE — American Indian, Black, White, etc.
Specify: white | | 22. 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | |
| 23. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Hotel Owner/Operator | | | | 24. 16b. KIND OF BUSINESS/INDUSTRY
Tourism | | 25. 17. FATHER'S NAME (First, Middle, Last)
William M. Griffin | |
| 26. 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Kate Brittingham | | | | 27. 19a. INFORMANT'S NAME (Type/Print)
Bo Moran | | 28. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Cedar Point RD Severna Park, MD 21146 | |
| 29. 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 30. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Cemetery 2/19/95 | | 31. 20c. LOCATION — City or Town, State
Berlin, MD | |
| 32. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 33. 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | 34. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

CARDIAC ARRHYTHMIA

HYPERTENSION | |
| 35. 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | 36. 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 37. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 38. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 39. 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 40. 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| 41. 28a. DATE OF INJURY (Month, Day, Year) | | | | 42. 28b. TIME OF INJURY
M | | 43. 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 44. 28d. DESCRIBE HOW INJURY OCCURRED | | | | 45. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 46. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 47. 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 48. 29b. SIGNATURE AND TITLE OF CERTIFIER
Stephen F. Waters MD | | 49. 29c. LICENSE NUMBER
027993 | |
| 50. 29d. DATE SIGNED (Month, Day, Year)
2-16-95 | | | | 51. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stephen F. Waters MD 1001 Philadelphia Avenue Ocean City, Md. | | 52. 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | |
| 53. 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | 54. 33. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | 55. 34. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FEB 16 1995

RECEIVED

NOV 10 1964

RECEIVED

NOV 10 1964

95 06690

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Patrick Wayne Cochran | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 21, 1995 | | 3. TIME OF DEATH
5:00 A. M. | |
| 4. SOCIAL SECURITY NUMBER
232-92-4616 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
September 28, 1956 | |
| 9a. FACILITY NAME (If not institution, give street and number)
811 Bellwood Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
California | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
California | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
811 Bellwood Lane | | | | 10f. ZIP CODE
20619 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Geologist | | 16b. KIND OF BUSINESS/INDUSTRY
Taylor Engineering | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Millard Cochran | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Wanda Wilson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Laurie A. Cochran | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
811 Bellwood Lane, California, Maryland 20619 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 2/22/95 | | 20c. LOCATION — City or Town, State
Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Edward N. Brinsfield, Jr. M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF):
Carcinomatous | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF):
Malignant Melanoma | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. Patrick Jarboe, M.D. | | | | 29c. LICENSE NUMBER
D06419 | | 29d. DATE SIGNED (Month, Day, Year)
2-21-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. Patrick Jarboe, M.D. Medical Arts Bldg., Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Charles Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06691

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Geneva Couser | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 18, 1995 | | | | 3. TIME OF DEATH
6:50 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER
577-32-3347 | | | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jun 10, 1921 | | 8. BIRTHPLACE (State or Foreign Country)
South Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | | | 9c. COUNTY OF DEATH
St. Mary's | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | | | 10c. CITY, TOWN OR LOCATION
Chaptico | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
215 Mill Point Road | | | | | | 10f. ZIP CODE
20621 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th Grade
College (13-16 or 17+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charlie Hutson | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Estelle Davenport | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Lemuel Couser | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
215 Mill Point Road, Chaptico, MD 20621 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 2/23/95 | | | | 20c. LOCATION — City or Town, State
Leonardtwn, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael H. Gardiner</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure 2 to</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>PRIMARY PNEUMONIA</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>AND Lung Cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. <i>(Left)</i> | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic artery disease</i>
<i>Adipose inflammation</i> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>K. M. M. MD</i> | | | | | | 29c. LICENSE NUMBER
<i>1236206</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>02/20/95</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>K. M. M. MD Leonardtown MD</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 21 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i>
<i>20650</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06692

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elsie Sophie Cheseldine | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 6, 1995 | | 3. TIME OF DEATH
2:35 p. M | |
| 4. SOCIAL SECURITY NUMBER
579-54-0464 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
2-3-1897 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Bayside Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lexington Park | | 9c. COUNTY OF DEATH
St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Leonardtwn | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Route 2 Box 1 Newtown Village | | | | 10f. ZIP CODE
20650 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
8th Grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Knapp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pauline | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Geraldine L. Savage | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6703 Tahalla Dr., Alexandria, Virginia 22306 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
All Saints Cemetery Feb. 9, 1995 | | 20c. LOCATION — City or Town, State
Avenue, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael Gardner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Cerebrovascular accident</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. James Boyd, M.D.</i> | | | | 29c. LICENSE NUMBER
019917 | | 29d. DATE SIGNED (Month, Day, Year)
2/7/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. James Boyd, M.D. Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 10 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06693

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Burke Combs | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 1, 1995 | | 3. TIME OF DEATH
9:58 P. M | |
| 4. SOCIAL SECURITY NUMBER
213-22-0272 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 3, 1912 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Box 41, Beachville Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
St. Inigoes | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
St. Inigoes | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
Box 41, Beachville Road | | | | 10f. ZIP CODE
20684 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Farmer | | 16b. KIND OF BUSINESS/INDUSTRY
Agriculture | |
| 17. FATHER'S NAME (First, Middle, Last)
Oscar Combs | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Geneive Elk | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Henrietta Combs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 41, Beachville Road, St. Inigoes, MD 20684 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Michael's Cemetery 2-4-95 | | 20c. LOCATION — City or Town, State
Ridge, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Edward N. Brinsfield, Jr. M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiorespiratory Failure
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
Carcinoma of the Lung
DUE TO (OR AS A CONSEQUENCE OF):
Testicular Carcinoma
Approximate interval Between Onset and Death
Wk
MO
yr | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. Patrick Jarboe, M.D. | | | | 29c. LICENSE NUMBER
D06419 | | 29d. DATE SIGNED (Month, Day, Year)
2-2-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. Patrick Jarboe, M.D. Medical Arts Bldg., Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 03 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Brinsfield | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06694

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frances Ruby Conway | | | | 2. DATE OF DEATH
MONTH DAY YEAR
January 28, 1995 | | 3. TIME OF DEATH
9:20 A M | |
| 4. SOCIAL SECURITY NUMBER
220-16-4820 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov 10, 1926 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | |
| 9c. COUNTY OF DEATH
St. Mary's | | | | 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | |
| 10c. CITY, TOWN OR LOCATION
California | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
Rt. 2 Box 107-33 | |
| 10f. ZIP CODE
20619 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | |
| 17. FATHER'S NAME (First, Middle, Last)
George Willard Clarke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julia Christine Newton | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Frank Lee Samuel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1636 St. Marie Ct., Virginia Beach, VA 23464 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 1/31/95 | | 20c. LOCATION — City or Town, State
Leonardtwn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael K. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute respiratory failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>and bleeding abdominal</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>acute anoxemia</i>
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Kiran Mehta MD</i> | | | | 29c. LICENSE NUMBER
36206 | | 29d. DATE SIGNED (Month, Day, Year)
1/30/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Kiran Mehta, M.D. Shanti Medical Center, Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 02 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06695

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DONALD ARTHUR CRANKSHAW | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 7, 1995 | | 3. TIME OF DEATH
11:11PM | |
| 4. SOCIAL SECURITY NUMBER
213-46-7608 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
08/12/44 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital at Easton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Preston | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
22197 Dover Bridge Road | | | | 10f. ZIP CODE
21655 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Printer | | 16b. KIND OF BUSINESS/INDUSTRY
Printing | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Harold G. Crankshaw | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bernice Calbitzor | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Phyllis A. Crankshaw | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22197 Dover Br. Rd., Preston, MD 21655 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Junior Order Cemetery 2-10 | | DATE | | 20c. LOCATION — City or Town, State
Preston, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael F. Eskow | | | | 22. NAME AND ADDRESS OF FACILITY
Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 21632 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
Years | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Obesity | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Thomas W. Fauntleroy | | | | 29c. LICENSE NUMBER
D 15315 | | 29d. DATE SIGNED (Month, Day, Year)
2-8-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Thomas W. Fauntleroy, M.D., 403 Marvel Ct., Easton, MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 10 95 | | 32. REGISTRAR'S SIGNATURE
John H. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06696

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elsie E. Cowgill | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 7 95 | | 3. TIME OF DEATH
5:50 P M | |
| 4. SOCIAL SECURITY NUMBER
219-07-6589 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 21, 1920 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital at Easton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Goldsboro | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10e. STREET AND NUMBER
15110 Greensboro Road | | | | 10f. ZIP CODE
21636 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
11 Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
lab technician | | 16b. KIND OF BUSINESS/INDUSTRY
food processing company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William H. Hutson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Stubbs Hutson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Betty Jean Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13602 Greensboro Road Greensboro, MD 21639 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olive Cemetery 2/11 | | 20c. LOCATION — City or Town, State
Sandtown, Delaware | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Steph C. Fluege</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small cell Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Peripheral Vascular Disease
pneumonia
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James Sides MD</i> | | | | 29c. LICENSE NUMBER
D31376 | | 29d. DATE SIGNED (Month, Day, Year)
2-8-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Sides, MD P.O. Box 496 Denton, MD 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 95 | | | | 32. REGISTRAR'S SIGNATURE
<i>Judith Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06697

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
REGINA MARIE COOPER | | | | 2. DATE OF DEATH
MONTH February DAY 10 YEAR 1995 | | 3. TIME OF DEATH
1:45 p.m. | |
| 4. SOCIAL SECURITY NUMBER
140-16-8485 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
June 3, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country)
New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number)
Doctors' Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Greenbelt | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
7702 Hanover Parkway, #204 | |
| 10f. ZIP CODE
20770 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Hostess | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last)
William Murphy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Agnes Slear | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert W. Cooper, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7702 Hanover Parkway, #204, Greenbelt, MD 20770 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Metropolitan Crematory 2/12/95 | | 20c. LOCATION — City or Town, State
Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles F. Beal</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Congestive heart failure
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute myocardial infarction
c. Diffuse coronary atherosclerosis | | | | | | | |
| Approximate interval Between Onset and Death
1 day
7 days
yrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Malastake lung carcinoma, Hypertension, Anemia, COPD, G.I. bleeding | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>D. R. Rustagi MD</i> | | | | 29c. LICENSE NUMBER
D 24270 | | 29d. DATE SIGNED (Month, Day, Year)
2-11-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
D. R. Rustagi, Cheverly
6132 Landover Rd., MD 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06698

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHERNETTA T. CONTEE | | | | 2. DATE OF DEATH
FEB 07 1995 | | 3. TIME OF DEATH
11:38 P.M. | |
| 4. SOCIAL SECURITY NUMBER
215-06-4365 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
25 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
6/12/69 | 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1108 Indo Place | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Desira Tinch | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Desira Contee | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1108 Indo Place, Hyattsville, Maryland 20785 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 2/15/95 | | 20c. LOCATION — City or Town, State
Landover | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Inawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. Jenkins Funeral Home
7474 Landover Road, Landover, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → STAB WOUND OF CHEST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
2/7/95 | | 28b. TIME OF INJURY
2250 P.M. | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
STREET | | 28e. DESCRIBE HOW INJURY OCCURRED
SUBJECT STABBED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 09, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIS JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06699

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HARVEY MELVIN COOPER, SR. | | | | | | 2. DATE OF DEATH
MONTH Feb. DAY 16 , YEAR 1995 | | 3. TIME OF DEATH
11:30 P M | |
| 4. SOCIAL SECURITY NUMBER
214-07-6468 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Oct 17, 1908 | | 8. BIRTHPLACE (State or Foreign Country)
PA | |
| 9a. FACILITY NAME (If not institution, give street and number)
14717 BRICE HOLLOW ROAD SE | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
14717 Brice Hollow Rd SE | | | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
12 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Retired | | 16b. KIND OF BUSINESS/INDUSTRY
Textile | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George W. Cooper | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edna (Wertz) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert Cooper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 171; Fort Ashby, WV 26719 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Tabor Cemetery | | DATE
02/19 | | 20c. LOCATION — City or Town, State
Oldtown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jane Z. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Poorly differentiated Carcinoma | | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Carcinoma Prostate Colon | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): 1992 | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John Z. Scarpelli | | | | | | 29c. LICENSE NUMBER
D23371 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 17, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Qamar Zaman; 625 Kent Avenue; Cumberland, MD 21502 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


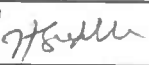

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06700

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES THOMAS CHIRELLI | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1995 | | 3. TIME OF DEATH
08:30 AM | |
| 4. SOCIAL SECURITY NUMBER
098-05-1580 | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
77 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
APRIL 7 1917 | 8. BIRTHPLACE (State or Foreign Country)
NEW YORK | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE
MARYLAND | 10b. COUNTY
ALLEGANY | 10c. CITY, TOWN OR LOCATION
CUMBERLAND | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
12713 WINCHESTER ROAD | | | 10f. ZIP CODE
21502 | 10g. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) 2 | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
FORK LIFT OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY
WHOLESALE DISTRIBUTION | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES THOMAS CHIRELLI | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROSE BUTTERMARK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LILLIAN P. CHIRELLI | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12713 WINCHESTER ROAD CUMBERLAND, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
RESTLAWN MEMORIAL GAR FEB 18 | | 20c. LOCATION — City or Town, State
LAVALE, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | 22. NAME AND ADDRESS OF FACILITY
HAFA CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY LAVALE, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
e. <i>Congestive heart failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Aortic valve prosthesis</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>Diastolic left ventricular dysfunction</i>
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death
<i>few weeks</i>
<i>few years</i>
<i>few weeks</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cholesterol of liver. Diabetes mellitus.</i> | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY
M | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | 29c. LICENSE NUMBER
528907 | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 15, 1995 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. HARJIT SIDHU, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502 | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06701

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
LILLIAN Lee Christian | | | | 2. DATE OF DEATH
MONTH Feb DAY 18 YEAR 1995 | | 3. TIME OF DEATH
8:30 PM | |
| 4. SOCIAL SECURITY NUMBER
223-40-4307 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
93 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH
(Month, Day, Year)
Dec 30, 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Harford Mem. Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Havre de Grace | | 9c. COUNTY OF DEATH
Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Aberdeen | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
645 Hickory Circle | | | | 10f. ZIP CODE
21001 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Christopher C. Canday | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ellen V. Davis | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Milton Christian | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
645 Hickory Circle Aberdeen, MD 21001 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Zion Bapt. Cem. 2-25 | | 20c. LOCATION — City or Town, State
Charles City, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Beard Funeral Home
552 Lewis St. Havre de Grace, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration pneumonia Resp failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
COA
ASCOOP
CAD | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M 1 | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

MD. | | | | 29c. LICENSE NUMBER
D20661 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. L. E. M.D. 307 S. Union Ave. Havre de Grace MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06702

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANTHONY LLOYD CAMERON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 13, 1995 | | 3. TIME OF DEATH
5:00 A M | |
| 4. SOCIAL SECURITY NUMBER
190-12-0980 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/13/1913 | |
| 9a. FACILITY NAME (If not institution, give street and number)
2712 Hitchcock Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
White Hall | | 9c. COUNTY OF DEATH
Harford | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
White Hall | |
| 10d. INSIDE CITY LIMITS?
1 YES 2 NO | | | | 10e. ZIP CODE
21161 | | | |
| 10f. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Farmer | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Calvin Cameron | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marie Borecky | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sharon M. Cameron | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Bel Air Mem. Gardens 2/17 Bel Air, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
M. Blackman Runtz III | | | | 22. NAME AND ADDRESS OF FACILITY
Kurtz Funeral Home Jarrettsville, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Parkinson's Disease - Advanced
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Subdural Hematomata
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
minutes
Years
Years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Christopher Riemann MD | | | | 29c. LICENSE NUMBER
MT033513T | | 29d. DATE SIGNED (Month, Day, Year)
February 17 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Christopher Riemann MD York Hospital York, PA 17405 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 06703

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BLANCHE LaMarr | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 19 YEAR 1995 | | | | 3. TIME OF DEATH
1:46 P | |
| 4. SOCIAL SECURITY NUMBER
577-16-1688 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 29, 1905 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Aquasco | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
17300 Aquasco Farm Road | | | | 10f. ZIP CODE
20608 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
1year | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Dental Hygienist | | 16b. KIND OF BUSINESS/INDUSTRY
Dentistry | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Edgar Canter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maggie Virginia Cross | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joycelyn A. Dalton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16304 St. Mary's Church Road Aquasco, MD 20608 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Oldfields Episcopal Ch. Cem. 02/24/95 Hughesville, MD | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Shirley Caporaletti M00844 | | | | 22. NAME AND ADDRESS OF FACILITY
The Hunt Funeral Home, Inc.
P.O. Box 156 Waldorf, MD 20604-0156 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. chronic fibrotic lung disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death
> 12 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
mild aortic stenosis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D 38388 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SUNIL NACHNANI M.D. 8926 Woodyard Rd. #601 CLINTON, MARYLAND 20735 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06704

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CAROLYN Matilda CARTER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 10 95 | | 3. TIME OF DEATH
2:50 A M | |
| 4. SOCIAL SECURITY NUMBER
137-14-9132 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-3-03 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Prince Georges County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Md | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Mitchellville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11805 Flora Lane | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (8-12) College (1-4 or 5+)
2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Public School | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mamie Jett | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Maureen Rogers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11805 Flora Lane Mitchellville Md. 20721 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 2-16 | | 20c. LOCATION — City or Town, State
Landover, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
J P Marshall | | | | 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home Inc
4217 9th Street, N. W.
Washington, D. C. 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death
—
yes |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
congestive heart failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
David L. Covering Attorney | | | | 29c. LICENSE NUMBER
020079 | | 29d. DATE SIGNED (Month, Day, Year)
2/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DON H. YABLONOWITZ 7404 EXECUTIVE PL. SUITE 2, JEFFERSON, MD 20706 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Wilbur Vernon Cook</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>2 24 95</i> | | 3. TIME OF DEATH
<i>8:17 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>213-20-3305</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>74</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Dec. 6, 1920</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Maryland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Stella Maris Hospice</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Towson</i> | |
| 9c. COUNTY OF DEATH
<i>Baltimore</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Baltimore</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Parkton</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>17104 Masemore Road</i> | |
| 10f. ZIP CODE
<i>21120</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<i>WW II</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Accountant</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Dept. of Recreation Baltimore Co.</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Charles Henry Cook</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Dorthea M. Rider</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Elva C. Cook</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>17104 Masemore Rd., Parkton, MD 21120</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE
<i>St. John's Feb 27 1995</i> | | | |
| 20c. LOCATION — City or Town, State
<i>Sweet Air, MD 21131</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<i>J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 17349</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pancreatic Carcinoma</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Enter significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cerebrovascular accident</i> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | |
| 29c. LICENSE NUMBER
<i>P36814</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>2/24/95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>1505 GLEN DRIVE SUITE 504 TOWSON 21093</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 02 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

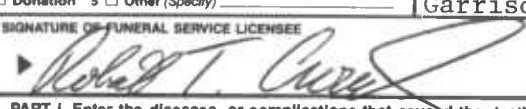
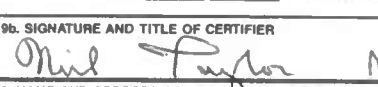
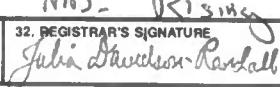
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06706

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lois Helen Canale | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 14, 1995 | | | | 3. TIME OF DEATH
5:58 A M | |
| 4. SOCIAL SECURITY NUMBER
458-28-4379 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
March 23 1925 | | | | 8. BIRTHPLACE (State or Foreign Country)
Texas | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
22 Edgewater Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
North East | | | | 9c. COUNTY OF DEATH
Cecil | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
North East | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
22 Edgewater Avenue | | | | 10f. ZIP CODE
21901 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Her own home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Warren Rice | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Hall | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Peter W. Canale | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 Edgewater Avenue, North East, Maryland 21901 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest Veteran Cem 2/17 | | | | 20c. LOCATION — City or Town, State
Owings Mills, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Crouch Funeral Home
127 South Main Street, North East Md 21901 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Carcinoma of lungs</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>A.S.C.V.D.</u>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death
6 months
5 yrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 MD | | | | 29c. LICENSE NUMBER
D-11115 | | | | 29d. DATE SIGNED (Month, Day, Year)
2-15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Neil Taylor MD - Rising Sun, Md. 21911 Northern Chesapeake Hospice | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06707

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BERTHA MARIE DONAWAY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 15 1995 | | 3. TIME OF DEATH
3:45 A M | |
| 4. SOCIAL SECURITY NUMBER
213-80-3563 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5/30/10 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Berlin Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Berlin | | 9c. COUNTY OF DEATH
Worcester | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Berlin | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11201 Grays Corner RD | | | | 10f. ZIP CODE
21811 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3
College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Farming | | 16b. KIND OF BUSINESS/INDUSTRY
Poultry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Andrew Burleigh Equart Chalmers | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Black | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Chalmers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11201 Grays Corner RD Berlin, MD 21811 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Riverside Cemetery 2/17/95 | | 20c. LOCATION — City or Town, State
Berlin, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Arteriosclerotic Heart Disease
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Generalized Atherosclerosis
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease; Alzheimer's
Aortic Valve Replacement; Hypertension
Severe Anemia; G.I. Bleeding | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D29505 | | 29d. DATE SIGNED (Month, Day, Year)
2-16-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gregorio Belloso, MD 4421 Beechwood Place Crisfield, MD 21817 410-968-1801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06708

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Bailey Disharoon | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 19 1995 | | 3. TIME OF DEATH
0610 M | |
| 4. SOCIAL SECURITY NUMBER
217-36-1087 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
9/16/23 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | |
| 9c. COUNTY OF DEATH
WICOMICO | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Snow Hill | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5804 Disharoon Road | | | | 10f. ZIP CODE
21863 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Farmer | | 16b. KIND OF BUSINESS/INDUSTRY
Own Farm | |
| 17. FATHER'S NAME (First, Middle, Last)
Wilson Disharoon, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara Sturgis Disharoon | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dianne Disharoon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5804 Disharoon Rd., Snow Hill, Md. 21863 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Bates Methodist Cem. 2/22/95, Snow Hill, Md. | | 20c. LOCATION — City or Town, State | | 20d. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Patricia L. Dennis | | | | 22. NAME AND ADDRESS OF FACILITY
Dennis Funeral Home, Snow Hill, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
3 DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CVA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert Allen M.D. | | | | 29c. LICENSE NUMBER
029168 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ROBERT ALLEN, M.D. 560 RIVERSIDE DR. APO4 SALISBURY, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06709

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>GEORGE T. THOMAS DOWNS</u> | | | | 2. DATE OF DEATH
MONTH <u>1</u> DAY <u>30</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>10:25 A M</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>220-16-8946</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>69</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>Feb. 3, 1925</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Maryland</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>St. Mary's Hospital</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Leonardtwn</u> | |
| 9c. COUNTY OF DEATH
<u>St. Mary's</u> | | | | 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>St. Mary's</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Avenue</u> | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>P.O. Box 104</u> | |
| 10f. ZIP CODE
<u>20609</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u> <u>College (1-4 or 5+)</u>
<u>10th grade</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Service Advisor</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Auto Dealership</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Stephen Downs</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Mary Agnes Hall</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Catherine L. Downs</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>P.O. Box 104, Avenue, Maryland 20609</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Charles Memorial Gardens 2/2/95</u> | | 20c. LOCATION — City or Town, State
<u>Leonardtwn, Maryland</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Michael L. Gardiner</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Mattingley-Gardiner Funeral Home, P.A.</u>
<u>P.O. Box 270, Leonardtown, Maryland 20650</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARCINOMA OF THE LUNG.</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Brain Met's</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
<u>N/A</u> | | 28b. TIME OF INJURY
<u>N/A</u> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
<u>N/A</u> | | | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)
<u>N/A</u> | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Dr. William C. Boyd, II</u> | | | | 29c. LICENSE NUMBER
<u>D-14285</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>1/30/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Dr. William C. Boyd, II Leonardtown, Maryland 20650</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>FEB 02 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Rodall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

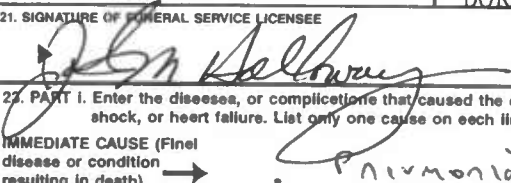

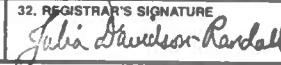
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06710

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FRANCIS LELLEWYN Daubert | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 13, 1995 | | 3. TIME OF DEATH
8:50 PM | |
| 4. SOCIAL SECURITY NUMBER
192-12-1163 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-14-25 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MD. | | | | 10b. COUNTY
WICOMICO | | 10c. CITY, TOWN OR LOCATION
EDEN | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
28464 OLD EDEN ROAD | | | |
| 10f. ZIP CODE
21822 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 7 College (1-4 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SHORE ENT. | | 16b. KIND OF BUSINESS/INDUSTRY
GAS & OIL | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM FRANKLIN DAUBERT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY ELIZABETH EIFERT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DANIEL F. DAUBERT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28464 OLD EDEN RD., EDEN, MD. 21822 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DORANCE CEM. | | 20c. LOCATION — City or Town, State
2-16-95 MOUNTAIN TOP, PA. | | 22. NAME AND ADDRESS OF FACILITY
HOLLOWAY FUNERAL HOME, P.A.
501 SNOW HILL RD., SALISBURY, MD. 21801 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
HOLLOWAY FUNERAL HOME, P.A.
501 SNOW HILL RD., SALISBURY, MD. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate interval Between Onset and Death
1 wk. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Dementia; Multiple Stage IV Aneurysms; Atrial Fibrillation; Sick Sinus Syndrome | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D44069 | | 29d. DATE SIGNED (Month, Day, Year)
2-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
106 MILFORD ST, SUITE 104 SALISBURY, MD. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06711

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Dorothy Douglas</u> | | | | 2. DATE OF DEATH
MONTH <u>2</u> DAY <u>10</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>8:50</u> ^A _M | |
| 4. SOCIAL SECURITY NUMBER
<u>220-12-2683</u> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>79</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>10/21/1915</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>3107 Good Hope Avenue #704</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Temple Hills</u> | | 9c. COUNTY OF DEATH
<u>Prince George's</u> | |
| 10a. STATE
<u>MD</u> | | 10b. COUNTY
<u>Prince George's</u> | | 10c. CITY, TOWN OR LOCATION
<u>Temple Hills</u> | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>3107 Good Hope Avenue #704</u> | | | | 10f. ZIP CODE
<u>20748</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>Black</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>8th Grade</u>
College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Domestic</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Private</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Robert Douglas</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Alice Douglas</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Thelma McCain</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>#C4
6008 Surrey Square, Forestville, Md. 20747</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Harmony Memorial Park</u> | | 20c. LOCATION — City or Town, State
<u>2-15 Landover, Maryland</u> | | 20d. DATE
<u></u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Mawana R. Braxton</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>J.B. Jenkins Funeral Home
7474 Landover Rd., Landover, Maryland 20785</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | <u>coronary artery disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
<u>Hypertensive arteriosclerosis</u>
DUE TO (OR AS A CONSEQUENCE OF):
<u>cardiovascular disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
<u></u> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Dr. Alfonso Valle, MD</u> | | | | 29c. LICENSE NUMBER
<u>D12879</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>Feb 14, 1994</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>DR Alfonso Valle 10701 TRAFLET DR. Largo, MD 20772</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>FEB 15 1995</u> | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

95 06712

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LOCKIE MORRISON DUZAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 16, 1995 | | 3. TIME OF DEATH
5:05 A M | |
| 4. SOCIAL SECURITY NUMBER
458-44-4544 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
100 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan 22, 1895 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Coffman Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hagerstown | | 9c. COUNTY OF DEATH
Washington | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Washington | | 10c. CITY, TOWN OR LOCATION
Hagerstown | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Coffman Nursing Home | | | | 10f. ZIP CODE
21742 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
School System | |
| 17. FATHER'S NAME (First, Middle, Last)
John Morrison | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Ann Batson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Virginia Lawhorn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2003 Heritage Drive Mt Washington, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hillcrest Cemetery Feb 20 | | 20c. LOCATION — City or Town, State
Temple, Texas | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stanley Lowman</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc
4112 Old Columbia Pike Ellicott City 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Demerol
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ASUD | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Arteriosclerosis | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Samuel Chan MD</i> | | | | 29c. LICENSE NUMBER
D36655 | | 29d. DATE SIGNED (Month, Day, Year)
2/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Samuel Chan, M.D. 1185 Mt. Aetna Road, Hagerstown, Maryland 21740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia D. Walker-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE GREAT WALL

THE GREAT WALL



95 06713

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Leary Willis L. Duff</u> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<u>February 18, 1995</u> | | 3. TIME OF DEATH
<u>3:15 PM</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>212-38-0195</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>54</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>July 2, 1940</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Maryland</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>Harford Memorial Hospital</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Havre de Grace</u> | |
| 9c. COUNTY OF DEATH
<u>Harford</u> | | | | 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Harford</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Aberdeen, Maryland</u> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>57 Smith Avenue</u> | |
| 10f. ZIP CODE
<u>21001</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<u>1959-1962</u> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Civil Service</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>U.S. Government</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>William Robert Duff</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Oleita Cullum</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Mrs. Shirley M. Duff</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>57 Smith Avenue, Aberdeen, Maryland 21001</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Grace Comm. Chapel Cemetery 2/21</u> | | 20c. LOCATION — City or Town, State
<u>Upper Cross Roads, MD</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Bursten Anzures</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory failure</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<u>myocardial infarction</u>
<u>pneumonia</u>
<u>CHF</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>J. Lee M.D.</u> | | | | 29c. LICENSE NUMBER
<u>D20661</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>2/18/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>J. T. Lee M.D. 307 S. Union Ave. Havre de Grace</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>FEB 21 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06714

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Evelyn Margaret Delaha</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>February 16, 1995</i> | | | | 3. TIME OF DEATH
<i>8:35 P M</i> | | | |
| 4. SOCIAL SECURITY NUMBER
<i>220-14-7045</i> | | | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
<i>87</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>August 26, 1907</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Harford Memorial Hospital</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Havre de Grace</i> | | | 9c. COUNTY OF DEATH
<i>Harford</i> | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
<i>Maryland</i> | | | 10b. COUNTY
<i>Harford</i> | | | 10c. CITY, TOWN OR LOCATION
<i>Havre de Grace</i> | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
<i>4031 Wilkinson Road</i> | | | | | | 10f. ZIP CODE
<i>21078</i> | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>white</i> | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Registered Nurse</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Medical</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Thomas A. Parks</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Susan Marie Joyce</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Sandra D. Winter</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2824 Aspen Hill Road, Baltimore, Maryland 21234</i> | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Mt. Zion Cemetery 2/20/95</i> | | | | 20c. LOCATION — City or Town, State
<i>Bel Air, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stephen A. Hughes</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md. 21009</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cerebrovascular accident (CVA)</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | | Approximate Interval Between Onset and Death
<i>5 days</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Clare MD</i> | | | | | | | |
| 29c. LICENSE NUMBER
<i>D31712</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>2/17/95</i> | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>CHARLES ECK JR 219 W. BELT RD APT A ABERDEEN, MD 21001</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 21 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Shuckler-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06715

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGE WILLIAM Dryden | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 12, 1995 | | 3. TIME OF DEATH
2358 M | |
| 4. SOCIAL SECURITY NUMBER
218-16-8086 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 3, 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
WICOMICO | | 10c. CITY, TOWN OR LOCATION
PARSONSBURG | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
32600 OLD OCEAN CITY ROAD | | | |
| 10f. ZIP CODE
21849 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DESK CLERK | | 16b. KIND OF BUSINESS/INDUSTRY
MOTEL | |
| 17. FATHER'S NAME (First, Middle, Last)
MILTON P. DRYDEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LOLA PERDUE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CARRIE M. DRYDEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32600 OLD OCEAN CITY ROAD, PARSONSBURG, MD 21849 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
WALSTON SWITCH CEMETERY | | DATE
2/15 | | 20c. LOCATION — City or Town, State
PARSONSBURG, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leonard D. Zeller</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ZELLER FUNERAL HOME, 1212 OLD OCEAN CITY RD
P.O. BOX 3171, SALISBURY, MD 21802 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Myocardial Infarction</i> Immediate | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Coronary Artery Disease</i> 30 yrs. | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John J. Burton, M.D.</i> | | 29c. LICENSE NUMBER
201126 | | 29d. DATE SIGNED (Month, Day, Year)
2/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
OSWALD J. BURTON, M.D., 540 RIVERSIDE DRIVE, SALISBURY, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06716

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHERBERT Sherbert S. Dowell | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15 1995 | | 3. TIME OF DEATH
3:15 A M | |
| 4. SOCIAL SECURITY NUMBER
218 12 0211 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
December 20, 1909 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Charlotte Hall Veterans Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Charlotte Hall | | 9c. COUNTY OF DEATH
Charles | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
St. Leonard | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
P.O. Box 471 4889 Calvert Street | | | |
| 10f. ZIP CODE
20685 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) WALT | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
self employed | | 16b. KIND OF BUSINESS/INDUSTRY
Radio Technician | |
| 17. FATHER'S NAME (First, Middle, Last)
Wilson Dowell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sadie Garner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Funice Humphrey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
611 Twin Cove Lane Dowell Maryland 20629 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Paul UMC Cemetery February 18, 1995 | | 20c. LOCATION — City or Town, State
Lusby Calvert Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
B. Rausch | |
| 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home | | 22. NAME AND ADDRESS OF FACILITY
4405 Brookes Is. Rd. Port Republic Maryland 20676 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d. | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PROSTATE CANCER, BLADDER CANCER | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
H. H. H. H. | | 29c. LICENSE NUMBER
226358 | |
| 29d. DATE SIGNED (Month, Day, Year)
FEB. 15, 1995 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOHN H. WEISS, MD - PRINCE FREDERICK, MD - 20628 | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 06717

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Eleanor Edmonds</i> ELEANOR EDMONDS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Jan. 1 23 23 85 | | 3. TIME OF DEATH
2100 M | |
| 4. SOCIAL SECURITY NUMBER
196-26-6494 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
95 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
MARCH 25, 1899 | |
| 9a. FACILITY NAME (If not institution, give street and number)
UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
CAROLINE | | 10c. CITY, TOWN OR LOCATION
PRESTON | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
21867 MARCH CREEK ROAD | | | | 10f. ZIP CODE
21655 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
NURSE | | 16b. KIND OF BUSINESS/INDUSTRY
NURSING | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM FRIEND | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LOTTIE CHASE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JEAN M. MONTERO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3861 N. 16th Street, PHILDEPHIA, PA. 19140 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. PLEASANT CEMETERY JAN. 28, 95 | | 20c. LOCATION — City or Town, State
PRESTON, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
BENNIE SMITH FUNERAL SERVICES
P.O. BOX 1687, EASTON, MD. 21601 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracranial bleed
DUE TO (OR AS A CONSEQUENCE OF):
b. Leukemic blast crisis
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Richard Ross MD</i> | | | | 29c. LICENSE NUMBER
Resident | | 29d. DATE SIGNED (Month, Day, Year)
1/23/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard Ross 27 S. Greene St. Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 02 95 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06718

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Aleen Gency Evans | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 18, 1995 | | 3. TIME OF DEATH
8:30 A M | |
| 4. SOCIAL SECURITY NUMBER
245-26-0328 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
June 21, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Havre de Grace | | 9c. COUNTY OF DEATH
Harford | |
| 9b. FACILITY NAME (If not institution, give street and number)
Harford Memorial Hospital | | | | 10a. STATE
Maryland | | 10b. COUNTY
Harford | |
| 10c. CITY, TOWN OR LOCATION
Aberdeen | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
103 Holloway Lane | |
| 10f. ZIP CODE
21001 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | |
| 16b. KIND OF BUSINESS/INDUSTRY
In home | | 17. FATHER'S NAME (First, Middle, Last)
Emory E. Maines | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillie M. Hash | | 19a. INFORMANT'S NAME (Type/Print)
Mrs. Robin A. Nickle | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
120 Remington Circle, Havre de Grace, MD 21078 | | 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harford Memorial Gardens | | 20c. LOCATION — City or Town, State
Aberdeen, Maryland | |
| 20d. DATE
2/21 | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Kirsten Amy Unglesbee | | 22. NAME AND ADDRESS OF FACILITY
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. CHRONIC PULMONARY DISEASE
b. CHRONIC BRONCHITIS
c. END STAGE COPD
d. PEPTIC ULCER DISEASE | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
2/18/95 | |
| 28b. TIME OF INJURY
8:30 PM | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Harford Memorial Hospital | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
P. H. H. M. M. | | 29c. LICENSE NUMBER
D4642 | |
| 29d. DATE SIGNED (Month, Day, Year)
2/18/95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
P. H. H. M. M. | | 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Anderson Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Charles Palmer ENGLAND</i> | | | 2. DATE OF DEATH
MONTH <i>FEB</i> DAY <i>14</i> YEAR <i>1995</i> | | 3. TIME OF DEATH
<i>2A</i> M |
| 4. SOCIAL SECURITY NUMBER
<i>217-36-3108</i> | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>89</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)
<i>December 13 1905</i> | 8. BIRTHPLACE (State or Foreign Country)
<i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Calvert Manor Nursing Home</i> | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Rising Sun</i> | | 9c. COUNTY OF DEATH
<i>Cecil</i> |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
<i>Maryland</i> | 10b. COUNTY
<i>Cecil</i> | 10c. CITY, TOWN OR LOCATION
<i>Rising Sun</i> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>1039 England Creamery Road</i> | | | 10f. ZIP CODE
<i>21911</i> | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i>
<i>12</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Dairy Farmer</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>His Own Farm</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Howard E. England</i> | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Edith Morris</i> | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Lorena E. England</i> | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1039 England Creamery Road, Rising Sun, MD 21911</i> | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Rosebank Cemetery</i> <i>2/17/95</i> | | 20c. LOCATION — City or Town, State
<i>Rising Sun, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | 22. NAME AND ADDRESS OF FACILITY
<i>Crouch Funeral Home</i>
<i>127 South Main Street, North East, MD 21901</i> | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cerebrovascular accident</i>
Due to (or as a consequence of):
b. <i>Previous CVA</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
<i>36 hr</i> | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Generalized arteriosclerosis</i> | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
<i>D 44102</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2/15/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 15 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06720

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anthony Fontaine | | | | 2. DATE OF DEATH
MONTH 02 DAY 15 YEAR 95 | | 3. TIME OF DEATH
4:15 A M | |
| 4. SOCIAL SECURITY NUMBER
215-90-0878 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
32 YRS. | IF UNDER 1 YEAR
MONTHS 02 DAYS 15 | IF UNDER 24 HRS.
HOURS 04 MIN 15 | 7. DATE OF BIRTH (Month, Day, Year)
11/29/62 | |
| 9a. FACILITY NAME (If not institution, give street and number)
University Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH
Maryland | |
| 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Salisbury | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
29289 Naylor Mill Road | | | | 10f. ZIP CODE
21801 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
None | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Fontaine SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Barbara Corbin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29289 Naylor Mill Rd. Salisbury, Md. 21801 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Acres | | DATE 2/18 | | 20c. LOCATION — City or Town, State
Salisbury, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gladys B. Stewart | | | | 22. NAME AND ADDRESS OF FACILITY
Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):

b. AIDS
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Gregory Kun Kunin, M.D.; Medical Resident | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gregory Kun Kunin, University of Maryland Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06721

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elizabeth W. Ford | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 14, 1995 | | 3. TIME OF DEATH
3:47 PM | |
| 4. SOCIAL SECURITY NUMBER
219-16-0285 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-30-21 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Physicians Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
La Plata | | 9c. COUNTY OF DEATH
Charles | |
| 10a. STATE
Maryland | | 10b. COUNTY
Charles | | 10c. CITY, TOWN OR LOCATION
Charles County | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
P.O. Box 1252 Bryans Road #1 | | | | 10f. ZIP CODE
20616 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Wheeler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minette Jackson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George M. Ford | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5500 Belva Street, Lanham, Maryland 20706 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park Ceme. 2/21/95 | | 20c. LOCATION — City or Town, State
Landover, Md. | | 20d. DATE
2/21/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart, III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME
4001 Benning Rd. N.E., Wash. D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>Acute myocardial infarction</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>Coronary atherosclerosis</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>Hypertension</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes mellitus, Acute pyelonephritis</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Paul E. Pritchett, M.D.</i> | | | | 29c. LICENSE NUMBER
D-08370 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul E. Pritchett, M.D.
118 La Grange Avenue, PO Box 1370
La Plata, Maryland 20646 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Anderson-Randall</i> | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06722

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET, FITZGERALD (Margaret Frances Fitzgerald) | | | | 2. DATE OF DEATH
MONTH February DAY 19 YEAR 1995 | | 3. TIME OF DEATH
5:15 A M | |
| 4. SOCIAL SECURITY NUMBER
213-30-0679 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 01, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Fallston General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fallston | | 9c. COUNTY OF DEATH
Harford | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Edgewood | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1105 Hanson Road | | | |
| 10f. ZIP CODE
21040 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
own home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas William Melvin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna (unknown) Ketchum | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Carroll E. Fitzgerald, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
424 Breslin Road, Joppa, Maryland 21085 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery 2/22 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stephen A. Hughes</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute CVA | | | | Approximate Interval Between Onset and Death
8 hrs | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Chronic CVA | | | | 8h | |
| | | c. Supraventricular Tachycardia | | | | 8h | |
| | | d. DKA (Diabetic Keto Acidosis) | | | | 24hrs | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Alcoholism
Cirrhosis with Portal Hypertension | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Manoj J. Mavey</i> | | | | 29c. LICENSE NUMBER
DZ6697 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Manoj J. Mavey MD, Fallston General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Johanna R. Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PHILLIP FLOWE | | | | 2. DATE OF DEATH
MONTH 2 DAY 13 YEAR 95 | | 3. TIME OF DEATH
5:29 P | |
| 4. SOCIAL SECURITY NUMBER
577-88-1569 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCT 27, 1958 | |
| 9a. FACILITY NAME (If not institution, give street and number)
LAUREL REGIONAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LAUREL | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
PRINCE GEORGES | | 10c. CITY, TOWN OR LOCATION
LAUREL | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
11676 S. LAUREL DR APT 8D | | | |
| 10f. ZIP CODE
20708 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LETTER CARRIER | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. POSTAL SERVICE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
TONY C. FLOWE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROSA WARE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROSA L. FLOWE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10603 Phillips DR UPPER MARLBORO, MD 20772 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MARYLAND NATIONAL CEMETERY | | 20c. LOCATION — City or Town, State
LAUREL, MARYLAND | | 20d. DATE
2/18 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Wesley J. Pyke Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
2617 Pennsylvania Ave. Forestville, MD 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Aspiration Pneumonia | | | | | |
| | | b. hypoxia | | | | | |
| | | c. Severe leukopenia | | | | | |
| | | d. Thrombotic penic | | | | | |
| | | e. ALCOHOLISM | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Drug abuse | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Retan-on | | | | 29c. LICENSE NUMBER
D 28998 | | 29d. DATE SIGNED (Month, Day, Year)
2-14-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
9101 Cherry Lane 211 Laurel MD 20708 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | 32. REGISTRAR'S SIGNATURE
John Davidson Hardall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06724

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DOROTHY FAISON | | | | 2. DATE OF DEATH
FEB 3, 1995 | | 3. TIME OF DEATH
2:20 A | |
| 4. SOCIAL SECURITY NUMBER
577-52-7549 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
SEPT. 23, 1932 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY, MD | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
MD | | | | 10b. COUNTY
PRINCE GEORGES | | 10c. CITY, TOWN OR LOCATION
CAPITOL HEIGHTS | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
506 MILLWOOF DRIVE | | | | 10f. ZIP CODE
20743 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SCHOOL TEACHER | | 16. KIND OF BUSINESS/INDUSTRY
EDUCATIONAL | | | |
| 17. FATHER'S NAME (First, Middle, Last)
DENNIS BRANDON | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
JULIA LEE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBERT R. FAISON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
506 MILLWOOF DRIVE, CAPITOL HGTS., MD 20743 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY | | 20c. LOCATION — City or Town, State
2/11/95 Alexandria, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Mrs. Pope Jr #859</i> | | | | 22. NAME AND ADDRESS OF FACILITY
POPE FUNERAL HOMES
5538 MARLBORO PIKE, FORESTVILLE, MD 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Non Hodgkin's Lymphoma</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jeffersonville, MD</i> | | | | | |
| | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 4, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JEFFERSONVILLE MD 10707 TRAFLET DR., LARGE, MD 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


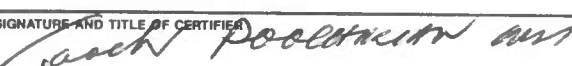

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/10/1911

95 06725

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EVELYN A. FREEMAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 7, 1995 | | 3. TIME OF DEATH
5:46 AM | |
| 4. SOCIAL SECURITY NUMBER
578-42-3407 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 9, 1920 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Prince George's Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Landover Hills | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
6818 Randolph Street | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Arthur D. Baker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carrie D. Farr | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert Freeman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6818 Randolph Street, Landover Hills, MD 20785 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 2/10/95 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, MD 20722 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Arrest</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Hypertension</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u>Hypoglycemia</u>
DUE TO (OR AS A CONSEQUENCE OF):
d. <u>Coronary Artery Disease</u>
Approximate interval between Onset and Death
1 hr
20 min
2 hr
25 min | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Diabetic nephropathy</u>
<u>Renal failure</u>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D34722 | | 29d. DATE SIGNED (Month, Day, Year)
2-7-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
V. Poochikian MD, 5632 Annapolis Rd, Bladensburg MD 20710 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 23; 2/21/95, SLW, Calvert Co.

95 06726

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN | | | | 2. DATE OF DEATH
MONTH: FEBRUARY DAY: 12 YEAR: 1995 | | | | 3. TIME OF DEATH
2014 | |
| 4. SOCIAL SECURITY NUMBER
202-16-1363 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jun 18, 1924 | | 8. BIRTHPLACE (State or Foreign Country)
PA | |
| 9a. FACILITY NAME (If not institution, give street and number)
1735 Forest Glen Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Prince Frederick | | | | 9c. COUNTY OF DEATH
Calvert | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Prince Frederick | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1735 Forest Glen Drive | | | | 10f. ZIP CODE
20678 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Auditor | | | | 16b. KIND OF BUSINESS/INDUSTRY
Insurance | |
| 17. FATHER'S NAME (First, Middle, Last)
Stephen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Lagaza | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martha Futchko | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1735 Forest Glen Drive Prince Frederick, MD 20678 | | | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 2-14-95 | | | | 20c. LOCATION — City or Town, State
Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home, PA Owings, MD 20736 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Cancer of Pancreas
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
2 mos
11 months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Type II diabetes, Coronary artery disease, Carotid artery disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Susan H. Prouty MD</i> | | | | | | 29c. LICENSE NUMBER
D25731 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0625-037

95-047

blh

95 06727

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
FRANCIS WILMER GRAVES JR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 05 1995 | | 3. TIME OF DEATH
1556 M | |
| 4. SOCIAL SECURITY NUMBER
212-38-7005 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan 15, 1935 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Route 5 (N) of Hill's Store | | 9b. CITY, TOWN OR LOCATION OF DEATH
Helen | |
| 9c. COUNTY OF DEATH
St. Mary's | | | | 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | |
| 10c. CITY, TOWN OR LOCATION
Avenue | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
109 Oakley Road | |
| 10f. ZIP CODE
20609 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1955 - 1959 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th Grade
College (1-4 or 5+) College | | | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Carpenter | | | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Francis Wilmer Graves, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Cora Belle Ryce | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Francis Wayne Graves | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 Oakley Rd., Avenue, MD 20609 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 2/10/95 | | | |
| 20c. LOCATION — City or Town, State
Leonardtown, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael A. Gardiner</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke Inhalation and Thermal Injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
2-5-95
28b. TIME OF INJURY
1548 M
28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
Passenger - Auto - Auto collision
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Roadway
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
RT 5 | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David R Fowler</i> | | | |
| 29c. LICENSE NUMBER
O.C.M.E. | | | | 29d. DATE SIGNED (Month, Day, Year)
Feb 06 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R Fowler
111 Penn Street, Baltimore, Maryland 21201 | | | | 31. DATE FILED (Month, Day, Year)
FEB 10 1995
32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06728

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Orville Paul Gould | | | | 2. DATE OF DEATH
MONTH February DAY 3, YEAR 1995 | | | | 3. TIME OF DEATH
9:00 A. M | |
| 4. SOCIAL SECURITY NUMBER
215-38-9964 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
March 1, 1912 | | | | 8. BIRTHPLACE (State or Foreign Country)
Iowa | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
#2 Troopers Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Piney Point | | | | 9c. COUNTY OF DEATH
St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Piney Point | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
#2 Troopers Road | | | | 10f. ZIP CODE
20674 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1934-1964 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Noncommissioned Officer | | | | 16b. KIND OF BUSINESS/INDUSTRY
Defense | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Oliver Gould | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie Bates | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Richard M. Gould | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
504 Enterprise Road, Lexington Park, Maryland 20653 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Joy Chapel Cemetery 2-7-95 | | | | 20c. LOCATION — City or Town, State
Hollywood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Edward N. Brinsfield, Jr.</i> M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year)
N/A | | 28b. TIME OF INJURY
N/A M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
N/A | | | | 28d. DESCRIBE HOW INJURY OCCURRED
N/A | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
N/A | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William D. Boyd II, M.D.</i> | | | | 29c. LICENSE NUMBER
D14285 | |
| 29d. DATE SIGNED (Month, Day, Year)
2/7/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William D. Boyd II, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650 | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06729

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PEARL GREEN | | | | 2. DATE OF DEATH
MONTH 02 DAY 06 YEAR 1995 | | | | 3. TIME OF DEATH
3:30 A M | |
| 4. SOCIAL SECURITY NUMBER
222-16-7608 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH
(Month, Day, Year)
01-07-1902 | | | | 8. BIRTHPLACE (State or Foreign Country)
DELAWARE | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
WESLEYAN HEALTH CARE CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
DENTON | | | | 9c. COUNTY OF DEATH
CAROLINE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
CAROLINE | | 10c. CITY, TOWN OR LOCATION
DENTON | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
420 COLONIAL DR, PO BOX 400 | | | | 10f. ZIP CODE
21629 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | | | 16b. KIND OF BUSINESS/INDUSTRY
HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
EDWARD KNOX | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY KNIGHT | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. JOSEPH GREEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BOX 460 LOMBARD STREET, FELTON DE 19943 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BARRATTS CHAPEL CEMETERY | | | | DATE 2-9 | | 20c. LOCATION — City or Town, State
FREDERICA, DE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George Short</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BERRY - SHORT FUNERAL HOME
119 NW FRONT ST, MILFORD DE 19963 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → diabetes
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate interval Between Onset and Death
years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
coronary artery disease
dementia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>J. Corwin M.D.</i> | | | | 29c. LICENSE NUMBER
D33768 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 6, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J CORWIN M.D. PO Box 660 DENTON MD 21629 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06730

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROSA GIBSON | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 8 YEAR 1995 | | | | 3. TIME OF DEATH
5:50 A M | |
| 4. SOCIAL SECURITY NUMBER
579-14-6711 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH
(Month, Day, Year)
3/20/1901 | | | | 8. BIRTHPLACE (State or Foreign Country)
South Carolina | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 10a. STATE
MD | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Landover | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7303 Goodland Dr. | | | | 10f. ZIP CODE
20785 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
6th grade | | 15b. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lawrence Gibson | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Mollie Burch | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Alice Carpenter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7303 Goodland Dr., Landover, Md. 20785 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park | | DATE
2-13 | | 20c. LOCATION — City or Town, State
Landover, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Juanana L. Braxton | | | | 22. NAME AND ADDRESS OF FACILITY
7474 Landover Rd., Landover, Maryland 20785
J.B. Jenkins Funeral Home | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PERFORATED GASTRIC ULCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death
1 WEEK | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE
RENAL FAILURE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MJ | | | | 29c. LICENSE NUMBER
0-18545 | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 8, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
P. WISOTSKY, MD 6188 OXON HILL RD, OXON HILL, MD 20745 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

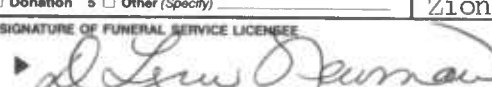
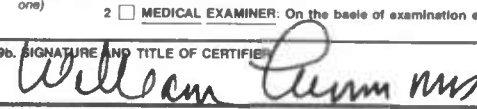
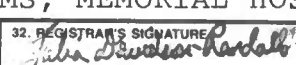
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06731

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JUANITA Elizabeth GOEHRINGER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 9 95 | | 3. TIME OF DEATH
9:55 AM | |
| 4. SOCIAL SECURITY NUMBER
218-34-4559 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug 14, 1936 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEMORIAL HOSPITAL & MED. CTR. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Garrett | | 10c. CITY, TOWN OR LOCATION
Accident | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
Route 219, South | | | | 10f. ZIP CODE
21520 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
3 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Owner/operator | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Kermit C. Bitteringer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Estella Beachy | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John M. Goehringer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Star Route, Box 7G, Accident, MD 21520 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Zion Cemetery 2-12-95 | | 20c. LOCATION — City or Town, State
Accident, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Newman Funeral Homes, P.A.
155 Main St., Grantsville, MD 21536 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Renal Cell Carcinoma
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
23406 D 16041 | | 29d. DATE SIGNED (Month, Day, Year)
2/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. TERRY WILLIAMS, MEMORIAL HOSP. MED. BLDG., CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSEPH WILLIAM GERMAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 15 95 | | 3. TIME OF DEATH
1620 M | |
| 4. SOCIAL SECURITY NUMBER
217-09-3832 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb 8, 1908 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Ellicott City | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
10510 Frederick Road | | | | 10f. ZIP CODE
21042 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Stone Mason | | 17. KIND OF BUSINESS/INDUSTRY
Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Benedict German | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catherine Boone | | | |
| 19a. INFORMANT'S NAME (Type/Print)
F. Louise German | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10510 Frederick Road Ellicott City, Maryland 21042 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. View Cemetery Feb 20 | | 20c. LOCATION — City or Town, State
Marriottsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stanley L...</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc
4112 Old Columbia Pike Ellicott City 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Progressive Liver Failure with massive Hepatic Necrosis Approximate Interval Between Onset and Death 3-4 wks | | | | | |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Congestive Heart Failure | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| Renal Failure | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Bert F. Morton, M.D.</i> | | | | 29c. LICENSE NUMBER
D08949 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bert F. Morton, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore, Md 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET ANN GAMBER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 8 1995 | | 3. TIME OF DEATH
9:00pm M | |
| 4. SOCIAL SECURITY NUMBER
214-74-3954 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 25 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Calvert Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rising Sun | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Rising Sun | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1881 Telegraph Rd | | | | 10f. ZIP CODE
21911 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (14 or 5+) unknown | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown Davis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen Reynolds | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kathleen Lockhart | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 189 Rising Sun MD 21911 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Feb 17 1995 BelAir Mem Gardens | | 20c. LOCATION — City or Town, State
BelAir MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Richard L. Goodie</i> | | | | 22. NAME AND ADDRESS OF FACILITY
R T Foard Funeral Home
111 S Queen St Rising Sun MD 21911 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive Heart Failure | | | | | Approximate interval Between Onset and Death
1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Severe Arterio Sclerosis and | | | | | 10 yrs |
| | | c. Coronary Artery disease | | | | | 10 yrs |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Malcolm Dudley Phillips MD</i> | | 29c. LICENSE NUMBER
D09482 | | 29d. DATE SIGNED (Month, Day, Year)
2/8/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)
2015 Trappe Church Rd DARLINGTON MD - Malcolm Dudley Phillips MD | | | | | | | |
| 31. DATE FILED
FEB 16 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPT. OF COMMERCE

OFFICE OF THE SECRETARY


WASHINGTON, D. C.



95 06734

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Brian Richard Guy | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 21, 1995 | | 3. TIME OF DEATH
6:30 p.m. | |
| 4. SOCIAL SECURITY NUMBER
504-80-8262 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
28 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 17, 1966 | | 8. BIRTHPLACE (State or Foreign Country)
South Dakota | |
| 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George | | 10c. CITY, TOWN OR LOCATION
Laurel | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9113 Contee Road #301 | | | | 10f. ZIP CODE
20708 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Interpreting | | 16b. KIND OF BUSINESS/INDUSTRY
Interpreter for Deaf | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Richard Guy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Adeline Clarice Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles Guy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
R.R. 2 Box 299 Veblen, South Dakota 57270 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Zion Lutheran Cemetery | | DATE
2/25 | | 20c. LOCATION — City or Town, State
Veblen, South Dakota | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home P.A.
313 Talbott Avenue Laurel, Maryland 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>pneumonia</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death
1-2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <u>neutropenia</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | ~1 wk. |
| | | c. <u>acute renal failure</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 1-2 days |
| | | d. <u>AIDS</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 2+ yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) | | | | | |
| | | HOSPITAL:
<input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | | | | |
| | | OTHER:
<input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY
(Month, Day, Year)
N/A | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED
N/A | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Susan Baruch MD | | | | 29c. LICENSE NUMBER
D39563 | | 29d. DATE SIGNED (Month, Day, Year)
2/22/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Susan Baruch 4743 Bradley Blvd. Chevy Chase, MD 20815 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 24 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Duckles-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06735

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
KATHRYN LUCILLE GROSS | | | | 2. DATE OF DEATH
FEB 18 1995 | | 3. TIME OF DEATH
9:19 A.M. | |
| 4. SOCIAL SECURITY NUMBER
212-28-5022 | | 5. SEX
1 M 2 F | 6. AGE (In yrs. last birthday)
64 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 13, 1930 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Joseph's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Bel Air | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10e. STREET AND NUMBER
441 Moores Mill Road | | | | 10f. ZIP CODE
21014 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
3 Widowed | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Fiscal Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
State of Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Ernest Barbour Maddox | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Hazel Marie Amos | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martha Gross | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
441 Moores Mill Road, Bel Air, Md. 21014 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Bel Air Memorial Gardens 2/21/95 | | 20c. LOCATION — City or Town, State
Bel Air, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SEPTIC SHOCK
DUE TO (OR AS A CONSEQUENCE OF):
b. ISCHEMIC BOWEL
DUE TO (OR AS A CONSEQUENCE OF):
c. ISCHEMIC VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| Approximate Interval Between Onset and Death
1 DAY
1 DAY
YEARS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 5 Pending Investigation
2 Accident
3 Suicide
4 Homicide 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D 41649 | | 29d. DATE SIGNED (Month, Day, Year)
2/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAY DINERMAN, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06736

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Milton Gordon | | | | 2. DATE OF DEATH
February 20, 1995 | | | | 3. TIME OF DEATH
1010 M | | | |
| 4. SOCIAL SECURITY NUMBER
216-18-5974 | | | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7. DATE OF BIRTH
Oct 3, 1904 | | | | 8. BIRTHPLACE (State or Foreign Country)
Wash. D.C. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Calvert Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Prince Frederick | | | | 9c. COUNTY OF DEATH
Calvert | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Sunderland | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
2416 Dalrymple Road | | | | 10f. ZIP CODE
20689 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: white | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
realtor, developer | | | | 16b. KIND OF BUSINESS/INDUSTRY
real estate | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Aaron Gordon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rachel Brown | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Florence Alta Gordon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as # 10 above | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 2/21/95 | | | | 20c. LOCATION — City or Town, State
Alexandria, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>William R. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home, P.A., Owings, MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | a. <i>Hyperkalemia</i> | | | | Approximate Interval Between Onset and Death
<i>2 hrs</i> | | | |
| | | | | b. <i>Renal Failure</i> | | | | <i>1 wk</i> | | | |
| | | | | c. <i>Congestive Heart Failure</i> | | | | <i>1 year</i> | | | |
| | | | | d. <i>Aortic Stenosis</i> | | | | <i>many yrs</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes Mellitus</i> | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Susan H. Prouty MD</i> | | | | 29c. LICENSE NUMBER
D 25731 | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06737

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Woodrow T. Higginbotham | | | | 2. DATE OF DEATH
MONTH DAY YEAR
2 22 95 | | 3. TIME OF DEATH
P 1200 | |
| 4. SOCIAL SECURITY NUMBER
233-28-8323 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 14, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtown | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Lexington Park | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
1500 Great Mills Road | | | | 10f. ZIP CODE
20653 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1942-1946 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
N/A | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
N/A Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
N/A Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Bayside Nursing Center | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1500 Great Mills Road, Lexington Park, MD 20653 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery 2/28/95 | | 20c. LOCATION — City or Town, State
Cheltenham | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Edward N. Brinsfield, Jr. M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Cerebrovascular Accident 2 mos</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>(Possible) Sepsis</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
David C. Allen, M.D. | | | | 29c. LICENSE NUMBER
02530 | | 29d. DATE SIGNED (Month, Day, Year)
2/23/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David C. Allen, M.D. 115 Washington Street, Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 28 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06738

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Pangie Grace L. Herring | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 24, 1995 | | 3. TIME OF DEATH
2:55P. | |
| 4. SOCIAL SECURITY NUMBER
231-58-4480 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 12, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Wrinkle Free Lane (Residence) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtown | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Leonardtown | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Route 2 Box 46 | | | |
| 10f. ZIP CODE
20650 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Finance Officer | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Walter Lambert | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sarah Rebecca Hardesty | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Doris Mattingly | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 2 Box 46, Leonardtown, Maryland 20650 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 2/28/1995 | | 20c. LOCATION — City or Town, State
Brentwoo, Maryland | | 20d. DATE
2/28/1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinomatosis
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Carcinoma of Lung
Approximate Interval Between Onset and Death
months
yes | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John Patrick Jarboe, M.D.</i> | | | | 29c. LICENSE NUMBER
D06419 | | 29d. DATE SIGNED (Month, Day, Year)
2/27/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. J. Patrick Jarboe, M.D. | | | | 31. DATE FILED (Month, Day, Year)
FEB 27 1995 | | | |
| 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06739

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Viola E. Hoeck</i> | | | | 2. DATE OF DEATH
MONTH <i>2</i> DAY <i>18</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>2030</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>192-26-6312</i> | | 5. SEX
<i>1</i> <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>85</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>July 26, 1909</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Pennsylvania</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>St. Mary's Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Leonardtwn</i> | |
| 9c. COUNTY OF DEATH
<i>St. Mary's</i> | | | | 10a. STATE
<i>Delaware</i> | | 10b. COUNTY
<i>Wilmington</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Wilmington</i> | | | | 10d. INSIDE CITY LIMITS?
<i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>2316 Kennwynn Road</i> | |
| 10f. ZIP CODE
<i>19810</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
<i>3</i> <input type="checkbox"/> Never Married <i>2</i> <input type="checkbox"/> Married
<i>3</i> <input checked="" type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>Homemaker</i> | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Homemaker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>John Brinson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Lena Paulsen</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Frederick K. Hoeck</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>114 Columbia St., Lexington Park, Maryland 20653</i> | | | |
| 20a. METHOD OF DISPOSITION
<i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State
<i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE
<i>Westminster Cemetery 2/23/95</i> | | | |
| 20c. LOCATION — City or Town, State
<i>Wilmington, Delaware</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael K. Gardiner</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<i>Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. <i>CONGESTIVE HEART FAILURE</i>
DUE TO (OR AS A CONSEQUENCE OF):

b. <i>COR PULMONALE</i>
DUE TO (OR AS A CONSEQUENCE OF):

c. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>
DUE TO (OR AS A CONSEQUENCE OF):

d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <i>1</i> <input checked="" type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA
OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation
<i>2</i> <input type="checkbox"/> Accident <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide <i>6</i> <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
<i>28b. TIME OF INJURY</i> <i>M</i>
<i>28c. INJURY AT WORK?</i> <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO
<i>28d. DESCRIBE HOW INJURY OCCURRED</i>
<i>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</i>
<i>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</i> | | | |
| 29a. CERTIFIER (Check only one)
<i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Shawn, MD</i> | | | |
| 29c. LICENSE NUMBER
<i>034535</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>2.20.95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>KHALID M. HUSMAN MD 662 MONROE ST #101 LEONARDTOWN MD 20650.</i> | | | | 31. DATE FILED (Month, Day, Year)
<i>FEB 21 1995</i> | | | |
| 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Amended #28a, 2/14/95, D&B St Mary's Co.

95 06740

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kerri Lee Hancock | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 2, 1995 | | | | 3. TIME OF DEATH
6:26 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
215-33-5197 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
3 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug 7, 1991 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | | | 9c. COUNTY OF DEATH
St. Mary's | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Callaway | | | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10a. STREET AND NUMBER
P.O. Box 92, Leonardtown Road | | | | 10f. ZIP CODE
20620 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
N/A | | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Marshall Hancock | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Angela Marie Hayden | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John M. Hancock | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 92, Leonardtown Rd., Callaway, MD 20620 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holy Face Cemetery 2/6/95 | | | | 20c. LOCATION — City or Town, State
Great Mills, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael L. Gardiner | | | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Fractured Skull + Neck,
DUE TO (OR AS A CONSEQUENCE OF):
b. Truck Tire Fell over
DUE TO (OR AS A CONSEQUENCE OF):
c. on child as she was playing
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year)
2.2.95 | | 28b. TIME OF INJURY
1730 M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Above | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)
Home - Garage | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Home. | | | | | | | | | |
| 29a. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Wm Boyd | | | | | | 29c. LICENSE NUMBER
D14285 | | | 29d. DATE SIGNED (Month, Day, Year)
2-3-95 | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Boyd, II, M.D. Leonardtown, Maryland 20650 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06741

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELLA MAE HULL | | | | 2. DATE OF DEATH
MONTH FEB. DAY 13 YEAR 1995 | | | | 3. TIME OF DEATH
1250 P | |
| 4. SOCIAL SECURITY NUMBER
220-03-6980 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH (Month, Day, Year)
3/15/1912 | | | | 8. BIRTHPLACE (State or Foreign Country)
Md. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | | 9c. COUNTY OF DEATH
WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Tyaskin | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4357 Tyaskin Road | | | | 10f. ZIP CODE
21865 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Home Maker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
William Kennedy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie Frances Peters | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Winifred S. Hull | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4321 Tyaskin/Nanticoke Road, Tyaskin, Md 21865 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Tyaskin Cemetery 2/18 Tyaskin, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> MOO-417 | | | | 22. NAME AND ADDRESS OF FACILITY
Messick Funeral Home, P.O. Box 61
Bivalve, Md. 21814 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Arteriosclerosis Embolus and Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
15089 | | 29d. DATE SIGNED (Month, Day, Year)
14 Feb 95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print)
ANDREW FORGASH, MD 500 RIVERSIDE DR. ARDG 5ALISBURY, MD 21801 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06742

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM HEATH | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 2 YEAR 1995 | | 3. TIME OF DEATH
11:35 A | |
| 4. SOCIAL SECURITY NUMBER
579-56-1904 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
51 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
November 10, 1943 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 9c. COUNTY OF DEATH
PRINCE GEORGE | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
WASHINGTON, D.C. | | 10c. CITY, TOWN OR LOCATION
Washington, D.C. | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3406 13th Place, S.E. | | | |
| 10f. ZIP CODE
20032 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8th | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Security Guard | | 16b. KIND OF BUSINESS/INDUSTRY
Greater S.E. Hospital | |
| 17. FATHER'S NAME (First, Middle, Last)
William Heath | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Matilda Jackson-Heath | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Botts/sister | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1335 Savannah St., S.E. #8 Wash., DC 20032 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glenwood Cemetery | | 20c. LOCATION — City or Town, State
Wash., D.C. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Elgie G. Rendi #866 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert G. Mason Funeral Home, Inc.
1661 Good Hope Rd., S.E. Wash., DC 20020 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death)
Symptomatic Human immunodeficiency virus.
DUE TO (OR AS A CONSEQUENCE OF):
Acquired immunodeficiency syndrome.
DUE TO (OR AS A CONSEQUENCE OF):
Pneumonia.
DUE TO (OR AS A CONSEQUENCE OF):
Cerebrovascular with dent.
Approximate Interval Between Onset and Death
2 yrs.
2 yrs.
2 weeks
many years. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
gastrostomy feeding tube | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
K. Dawack MD | | | | 29c. LICENSE NUMBER
D25640 | | 29d. DATE SIGNED (Month, Day, Year)
2/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
K HASANOW DAWACK 1328 SOUTHERN AVENUE WASHINGTON DC 20032 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
John W. H. H. H. | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ETAHJAYNE MORGAN-HARRIS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 2, 1995 | | 3. TIME OF DEATH
4:12 P M | |
| 4. SOCIAL SECURITY NUMBER
219-94-8970 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov 6, 1959 | |
| 8a. FACILITY NAME (If not institution, give street and number)
1830 BRONZE GATE | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRINGS | | 8c. COUNTY OF DEATH
MONTGOMERY | |
| 9. RESIDENCE OF DECEDENT
10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
11963 Old Columbia Pike | | 10f. ZIP CODE
20904 | |
| 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) Six Years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Int. Development Spec | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | |
| 17. FATHER'S NAME (First, Middle, Last)
James Edward Morgan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elfrieda Ricks | | | |
| 19a. INFORMANT'S NAME (Type/Print)
David V. Harris, Husband | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11963 Old Columbia Pike, Silver Spring, Md 20904 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 2/11/95 S. S. Md | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
JOHNSON & JENKINS Inc.
716 Kennedy Street, NW., D. C. 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SICKLE CELL ANEMIA
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB 3, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95-0673-033

DWG

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/8/95 t.t

95 06744

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FEARON | | | | 2. DATE OF DEATH
MONTH FEB. DAY 08 YEAR 95 | | | | 3. TIME OF DEATH
09:23A M | |
| 4. SOCIAL SECURITY NUMBER
N/A | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
57 YRS. | | IF UNDER 1 YEAR
MONTHS 00 DAYS 00 | | IF UNDER 24 HRS.
HOURS 00 MIN. 00 | |
| 7. DATE OF BIRTH
(Month, Day, Year)
OCT. 13, 1937 | | | | 8. BIRTHPLACE (State or Foreign Country)
JAMAICA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | | | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
MITCHELLVILLE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1522 KINGS HILL STREET | | | | 10f. ZIP CODE
20721 | | 10g. CITIZEN OF WHAT COUNTRY?
JAMAICA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
OFFICE CLERK | | | | 16b. KIND OF BUSINESS/INDUSTRY
GOVT. | |
| 17. FATHER'S NAME (First, Middle, Last)
SYDNEY HYMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HELEN BURKE | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
KENNETH HYMAN/ BROTHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33169
18820 NORTH WEST 8th AVENUE MIAMI, FLORIDA | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) out of country | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BRIGHTON DISTRICT | | 20c. LOCATION — City or Town, State
2-18 SANTA CRUZ, JAMAICA | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Shawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME
7474 LANDOVER ROAD LANDOVER, MD 20785 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIABETES MELLITUS
DUE TO (OR AS A CONSEQUENCE OF):

b.
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John A. Davidson-Randall</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 09, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GARCIA JR. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John A. Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06745

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
IRVIN HENNEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14, 1995 | | 3. TIME OF DEATH
0941 P M | |
| 4. SOCIAL SECURITY NUMBER
213-18-2831 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jul 20, 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND, MD | | 9c. COUNTY OF DEATH
ALLEGANY | | | |
| 10a. STATE
MD | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Oldtown | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Route 1 Box 100 | | | |
| 10f. ZIP CODE
21555 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Retired Farmer | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Michael B. Hennen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary (Egans) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George Fletcher | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 9 Box 218; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glendale Cemetery | | DATE
02/17 | | 20c. LOCATION — City or Town, State
Flintstone, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
James J. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Probable Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
30 Minutes
unknown |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. Gupta | | | | 29c. LICENSE NUMBER
D33280 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 15, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. GUPTA JOHNSON HEIGHTS MEDICAL BLDG CUMBERLAND MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
Jana Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06746

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ERNEST W. HENDERSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 9, 1995 | | 3. TIME OF DEATH
11:10 P M | |
| 4. SOCIAL SECURITY NUMBER
232-26-5432 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 27, 1898 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cumberland | | 9c. COUNTY OF DEATH
Allegany | |
| 10a. STATE
W. Va. | | 10b. COUNTY
Morgan | | 10c. CITY, TOWN OR LOCATION
Great Cacapon | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER
HC 62 Box 98 | | | | 10f. ZIP CODE
25422 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Self | | 16b. KIND OF BUSINESS/INDUSTRY
Farmer and Carpenter | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Franklin Henderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice Keller | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Merle L. Henderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 4 Box 415 Berkeley Springs, W.Va. 25411 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodrow Cemetery Feb. 13, 1995 | | 20c. LOCATION — City or Town, State
Paw Paw, W. Va. | | 20d. DATE
Feb. 13, 1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Miller Funeral Homes, Inc.
P.O. Drawer 1000 Romney, W.Va. 26757 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive CVA
DUE TO (OR AS A CONSEQUENCE OF): Actual fibrillation embolus
DUE TO (OR AS A CONSEQUENCE OF): Ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF): with congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
1d |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Probable mesothelioma embolus earlier | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
D 14393 | | 29d. DATE SIGNED (Month, Day, Year)
10 Feb 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 21) (Type, Print)
Dr. F. Miltenberger, Johnson Heights Medical Bldg., Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06747

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Joan Catherine Hyman | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 18 1995 | | 3. TIME OF DEATH
1:57 a.m. | |
| 4. SOCIAL SECURITY NUMBER
066-30-4089 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 01, 1938 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
620 E. MacPhail Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bel Air | | 9c. COUNTY OF DEATH
Harford | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Bel Air | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
620 E. MacPhail Road | | | | 10f. ZIP CODE
21014 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mex./can, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Medical Office | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Frank Dulak | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eugenia Louise Schwelicher | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mark P. Hyman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3030 Bellchase Road, Fallston, Maryland 21047 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Mary's Cemetery | | DATE
2/22 | | 20c. LOCATION — City or Town, State
Lock Haven, Penn. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Howard K. McComas III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER
Approximate Interval Between Onset and Death: 5 years
Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Joan P. Edwards MD</i> | | 29c. LICENSE NUMBER
D31775 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 19, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOAN P. EDWARDS 2112 BELAIR ROAD FALLSTON, MARYLAND 21047 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Ruskell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06748

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Elsie Magdalen Hughes | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 9, 1995 | | 3. TIME OF DEATH
8:30 P M | |
| 4. SOCIAL SECURITY NUMBER
557-42-9749 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 14, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Forestville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8100 Jordon Park Blvd. | | | | 10f. ZIP CODE
20747 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (8-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
D.C. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Bradshaw | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Bowles | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anthony Hughes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8100 Jordon Park Blvd. Forestville, MD 20747 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cem. Feb 14, 1995 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, MD 20735 | | | |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Carcinoma Lung

c.

d.

Approximate interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D45435 | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
V. Mathew M.B. 3710 Riviera Street, Marlow Heights, MD 20746 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06749

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Evelyn Reeves Heflin | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 15, 1995 | | 3. TIME OF DEATH
4:23 P M | |
| 4. SOCIAL SECURITY NUMBER
578-22-0310 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS
70 | | 7. DATE OF BIRTH
(Month, Day, Year)
6/21/24 | |
| 9a. FACILITY NAME (If not institution, give street and number)
1825 Tucker Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Ft. Washington, | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2307 Erskine St. | | | | 10f. ZIP CODE
20783 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George N. Hettenkemmer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Irene Virginia Bladen | | | |
| 19a. INFORMANT'S NAME (Type/Print)
L. Darlene Soresi | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1825 Tucker Rd. Ft. Washington, Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State
Brentwood, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinoma of the Vulva</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate Interval Between Onset and Death
9 yrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
M
28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Lucio S. Villa-Real MD</i> | | | | 29c. LICENSE NUMBER
D 15513 | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LUCIO S. VILLA-REAL, M.D. - #2 ST. PATRICK'S DRIVE, WALDORF, MD. 20603 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06750

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ERNEST HALTON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 13, 1995 | | 3. TIME OF DEATH
2:15AM | |
| 4. SOCIAL SECURITY NUMBER
578-18-1680 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
04-17-18 | |
| 9a. FACILITY NAME (If not institution, give street and number)
GLADYS SPELMAN SPECIALITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
District of Columbia | | | | 10b. COUNTY
Washington | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1729 Evarts Street N.E. | | | | 10f. ZIP CODE
20018 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Retired Librarian | | 16b. KIND OF BUSINESS/INDUSTRY
Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Ernest Halton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
T.J. Noble | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dora S. Halton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1729 Evarts Street N.E., Wash. D.C. 20018 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Quantico Nat'l. Ceme. 2/17/95 | | 20c. LOCATION — City or Town, State
Triangle, Va. | | 20d. DATE
2/17/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart, III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME
4001 Benning Rd. N.E., Wash. D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. GANGRENE LEFT FOOT.
DUE TO (OR AS A CONSEQUENCE OF):
d. STROKE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
> 24 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD - S/P - CABG; H/O - PROSTATE CA. HEMATURIA; He was DNR. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
N/A | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S-J. Rao</i> | | | | 29c. LICENSE NUMBER
D-34525 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S-J. RAO, MD; 4000 MITCHELLVILLE ROAD; #220; BOWIE-MD-20716 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06751

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Dennis E. Himes | | | | 2. DATE OF DEATH
MONTH DAY YEAR
January 31, 1995 | | 3. TIME OF DEATH
8:00 P. M. | |
| 4. SOCIAL SECURITY NUMBER
220-62-9937 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 27, 1955 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
9086 Old Scaggsville Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | |
| 9c. COUNTY OF DEATH
Howard County | | | | 10a. STATE
Maryland | | 10b. COUNTY
Howard County | |
| 10c. CITY, TOWN OR LOCATION
Laurel | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
9086 Old Scaggsville Road | |
| 10f. ZIP CODE
20723 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY
Self-Employed | |
| 17. FATHER'S NAME (First, Middle, Last)
Lee A. Himes, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Betty Wheaton | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Darlene M. Himes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9086 Old Scaggsville Rd., Laurel, Maryland 20723 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 2/3/95 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, MD 20722 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain tumor - Anaplastic Astrocytoma
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
18 mo | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D37018 | | 29d. DATE SIGNED (Month, Day, Year)
2/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John J. Laterna MD Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


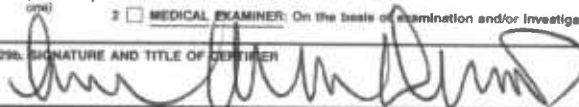

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06752

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ellen Rebecca Hammonds | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 8, 1995 | | 3. TIME OF DEATH
0011 A ^M | |
| 4. SOCIAL SECURITY NUMBER
577-20-9368 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 8, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park | |
| 9c. COUNTY OF DEATH
Montgomery County | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Cottage City | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
3709 40th Avenue | |
| 10f. ZIP CODE
20722 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
City Government | |
| 17. FATHER'S NAME (First, Middle, Last)
George Rowe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sadie Swimmer | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Harold W. Hammonds | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3709 40th Avenue, Cottage City, Maryland 20722 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 2/11/95 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, MD 20722 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC SQUAMOUS CELL CARCINOMA WITH METS TO THE BRAIN
Approximate Interval Between Onset and Death
6 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D01499 | | 29d. DATE SIGNED (Month, Day, Year)
2/9/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. LEWIS HILLIARD DENNIS 6201 GREENBELT RD. #U-1 COLLEGE PARK, MD 20740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06753

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Eli Hamilton | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 17 1995 | | 3. TIME OF DEATH
1:56 P M | |
| 4. SOCIAL SECURITY NUMBER
139-05-5702 | | 5. SEX
XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec 17, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Dorchester General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cambridge | | 9c. COUNTY OF DEATH
Dorchester | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Dorchester | | 10c. CITY, TOWN OR LOCATION
Cambridge | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4174 Griffith Neck Road | | | | 10f. ZIP CODE
21613 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES XX NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES XX NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Shipwright | | 16b. KIND OF BUSINESS/INDUSTRY
Naval Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George C. Hamilton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillian Williamson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William G. Hamilton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Laurel Drive Mullica Hill, New Jersey 08062 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
East New Market Cemetery 2/20 East New Market, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Thomas Funeral Home
700 Locust St. Cambridge, Maryland 21613 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF):
b. Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death
24 hrs
3 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
William Bair | | 29c. LICENSE NUMBER
D43238 | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Bair 19 Franklin Street Cambridge, MD 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.


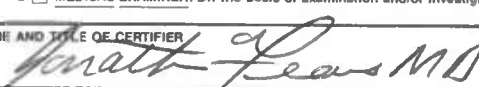

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06754

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Luther Samuel Horne | | | | 2. DATE OF DEATH
MONTH 2 DAY 20 YEAR 95 | | 3. TIME OF DEATH
11:00 P M | |
| 4. SOCIAL SECURITY NUMBER
242-22-3715 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
79 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS
HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year)
Sep 1, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country)
NC | | | | 9. COUNTY OF DEATH
Calvert | | | |
| 10. FACILITY NAME (If not institution, give street and number)
11450 Little Cove Point Road | | | | 11. CITY, TOWN OR LOCATION OF DEATH
Lusby | | 12. COUNTY OF DEATH
Calvert | |
| 10a. STATE
MD | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Lusby | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11450 Little Cove Point Road | | | | 10f. ZIP CODE
20657 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
heavy equipment operator | | 16b. KIND OF BUSINESS/INDUSTRY
road construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
David Allison Horne | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pearlie C. Chapman | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charlie Everett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as # 10 above | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Iredell Memorial Gardens | | DATE
2/21/95 | | 20c. LOCATION — City or Town, State
Statesville, NC | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home, P.A., Owings, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic cancer of the lung
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastatic cancer of the lung
c. metastatic cancer of the lung
d. metastatic cancer of the lung | | | | | | | Approximate Interval Between Onset and Death
3 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic lymphocytic leukemia, anemia, thrombocytopenia, hypercalcemia. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
139522 | | 29d. DATE SIGNED (Month, Day, Year)
2/21/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
120 Hospital Rd, Dr. Frederick, MD 20678 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
TREVOR LEWIS HOBBS | | | | 2. DATE OF DEATH
MONTH FEB DAY 17 YEAR 1995 | | 3. TIME OF DEATH
7:50 A M | |
| 4. SOCIAL SECURITY NUMBER
222-82-3265 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
2 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
8-22-92 | |
| 9a. FACILITY NAME (If not institution, give street and number)
379 CYPRESS STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
MILLINGTON | | 9c. COUNTY OF DEATH
KENT | |
| 10a. STATE
MD | | 10b. COUNTY
KENT | | 10c. CITY, TOWN OR LOCATION
MILLINGTON | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
379 CYPRESS STREET | | | | 10f. ZIP CODE
21651 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
NEVER WORKED | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
GARY SCOTT HOBBS, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
THERESA M. HOBBS (NEE: PALMER) | | | |
| 19a. INFORMANT'S NAME (Type/Print) (FATHER)
MR. GARY S. HOBBS, SR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31 LINDEN ST., CLAYMONT, DELAWARE 19703 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SILVERBROOK CEMETERY 2-22-95 | | 20c. LOCATION — City or Town, State
WILMINGTON, DELAWARE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Chandler H. Gebhart, III | | | | 22. NAME AND ADDRESS OF FACILITY
GEBHART FUNERAL HOME
CLAYMONT & NEW CASTLE, DELAWARE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Smoke Inhalation
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year)
2/17/95 | | 28b. TIME OF INJURY
0730 M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED
Victim of housefire | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
379 CYPRESS ST. | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John L. W. MD | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB 18, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia Ann W. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Ann W. MD | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GARY SCOTT HOBBS, II | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 17, 1995 | | 3. TIME OF DEATH
7:50 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
222-80-8921 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
4 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-6-91 | | 8. BIRTHPLACE (State or Foreign Country)
WILMINGTON, DE | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
379 CYPRESS STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
MILLINGTON | | | | 9c. COUNTY OF DEATH
KENT | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
KENT | | 10c. CITY, TOWN OR LOCATION
MILLINGTON | | | | 10d. INSIDE CITY LIMITS?
1 X YES 2 NO | | | |
| 10e. STREET AND NUMBER
379 CYPRESS STREET | | | | 10f. ZIP CODE
21651 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | |
| 11. MARITAL STATUS
1 X Never Married 2 Married
3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 0
College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
NEVER WORKED | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
GARY SCOTT HOBBS, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
THERESA M. HOBBS (NEE: PALMER) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. GARY S. HOBBS, SR. (FATHER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31 LINDEN ST., CLAYMONT, DELAWARE 19703 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SILVERBROOK CEMETERY 2-22-95 | | 20c. LOCATION — City or Town, State
WILMINGTON, DELAWARE | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Chandler H. Gebhart, III | | | | 22. NAME AND ADDRESS OF FACILITY
GEBHART FUNERAL HOME
CLAYMONT & NEW CASTLE, DELAWARE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke Inhalation
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 X YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 X YES 2 NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 X YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 X Residence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 X Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
2/17/95 | | 28b. TIME OF INJURY
0730 M | | 28c. INJURY AT WORK?
1 YES 2 X NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Victim of Housefire | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Home | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
379 CYPRESS ST. | | | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
David L. Wolfe MD | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB 18, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TRALON WOLFE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | | | | |



95 06757

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anna Lissie Halsey | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 11, 1995 | | | | 3. TIME OF DEATH
0908 M | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-20-8010 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
May 31, 1919 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
Union Hospital of Cecil County | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Elkton | | | | 9c. COUNTY OF DEATH
Cecil | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Elkton | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
345 Hollingsworth Manor | | | | | | 10f. ZIP CODE
21921 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Arter Hayes | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Dora Brooks | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Lou Slagle | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
207 Prairie Drive, Apt. E - Elkton, MD 21921 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gilpin Manor Memorial Park 2-13 1995 | | | | 20c. LOCATION — City or Town, State
Elkton, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James S. Hicks</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Hicks Home for Funerals, P.A.
103 West Stockton Street
Elkton, MD 21921-5521 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebral Hemorrhage</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Atherosclerosis</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate interval Between Onset and Death
24 hr | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY
M | | 26c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | | | |
| 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Patricia Greve M.D.</i> | | | | | | 29c. LICENSE NUMBER
D22813 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Patricia Greve, M.D. - 111 West High Street - Elkton, MD 21921 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 06758

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Irma E. Haegele</i> | | | | 2. DATE OF DEATH
MONTH <i>Feb.</i> DAY <i>14</i> YEAR <i>1995</i> | | 3. TIME OF DEATH
<i>11 25 P M</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER
<i>140-20-2024</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>90</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>March 16, 1904</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>New Jersey</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Calvert Manor Nursing Home</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Rising Sun</i> | | | | 9c. COUNTY OF DEATH
<i>Cecil</i> | | | |
| 10a. STATE
<i>New Jersey</i> | | 10b. COUNTY
<i>Gloucester</i> | | 10c. CITY, TOWN OR LOCATION
<i>Pitman</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
<i>20 East Woodland Avenue</i> | | | | 10f. ZIP CODE
<i>08071</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Unknown</i> | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Cafeteria Worker</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Education</i> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Thomas Miller</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Ella Norcross</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Robert Haegele</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>20 East Woodland Avenue - Pitman, NJ 08071</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Cedar Green Cemetery</i> | | DATE
<i>2-17-1995</i> | | 20c. LOCATION — City or Town, State
<i>Clayton, New Jersey</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Donald S. Hicks</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Hicks Home for Funerals, P.A.
103 West Stockton Street
Elkton, MD 21921-5521</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>Coronary heart failure</i>

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>A.S.C.V.D.</i>

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death
<i>10 days</i>
<i>5 yrs</i> | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Paul Taylor MD</i> | | | | | | 29c. LICENSE NUMBER
<i>011115</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2-14-95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 17) (Type, Print)
<i>Paul R Taylor MD Rising Sun MD 21911</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 15 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06759

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Nathaniel James Chester Nathaniel James | | | | 2. DATE OF DEATH
MONTH 2 DAY 19 YEAR 95 | | 3. TIME OF DEATH
5:50 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER
221-09-1292 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
85 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
10/27/09 | | 8. BIRTHPLACE (State or Foreign Country)
DE | |
| 9a. FACILITY NAME (If not institution, give street and number)
Atlantic General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Berlin | | | | 9c. COUNTY OF DEATH
Worcester | | | |
| 10a. STATE
MD | | | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Ocean City | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7208 Coastal Highway | | | | 10f. ZIP CODE
21842 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 8+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Owner/Operator Basket Factory | | | | 16b. KIND OF BUSINESS/INDUSTRY
Farming Supply | | | |
| 17. FATHER'S NAME (First, Middle, Last)
J. Alvin James | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillie Rogers | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rosalee Quillen James | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7208 Coastal Highway Ocean City, MD 21842 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Buckingham Cemetery 2/22/95 | | DATE
Berlin, MD | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. cerebral vascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death
5 days
5 days
10 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
 | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
 | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
 | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER
H44483 | | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert Durkin 9733 Heritance Drive Berlin, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

THE NEW YORK
LIBRARY

1850

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MELINDA ANN JOHNSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
JAN 31 95 | | 3. TIME OF DEATH
8:11A M | |
| 4. SOCIAL SECURITY NUMBER
212-19-8014 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
16 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 13, 1978 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PHYSICIANS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LA PLATA | | 9c. COUNTY OF DEATH
CHARLES COUNTY | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Charlotte Hall | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Rt. 2 Box 96 | | 10f. ZIP CODE
20622 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+)
10th Grade | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Student | | | | 16b. KIND OF BUSINESS/INDUSTRY
High School | | 17. FATHER'S NAME (First, Middle, Last)
James Edward Johnson, Sr. | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Debra Ann Wise | | | | 19a. INFORMANT'S NAME (Type/Print)
James E. Johnson, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 96, Charlotte Hall, MD 20622 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
Queen of Peace Cemetery 2/3/95 | | 20c. LOCATION — City or Town, State
Helen, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael K. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE INJURIES
Due to (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Due to (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
XX YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
XX YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Undetermined | | | | 28a. DATE OF INJURY (Month, Day, Year)
1/31/95 | | 28b. TIME OF INJURY
7:03P M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
MOTOR VEHICLE ACCIDENT | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Rte 5 & COCKSEY SWAMP/ST. MARY'S | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Theodore M. King M.D.</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 01/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 02 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06761

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Grace Mabel JACKSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 7 1995 | | 3. TIME OF DEATH
4:57 a ^m | |
| 4. SOCIAL SECURITY NUMBER
228-42-2650 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 31, 1903 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital at Easton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Goldsboro | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Maryland Route 313 | | | | 10f. ZIP CODE
21636 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11
College (1-4 or 5+) 2 | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Sales Lady | | 18b. KIND OF BUSINESS/INDUSTRY
Clothing | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter Rutter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Lucas | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martha J. Delphey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2605 Arcola Avenue, Silver Spring, Maryland 20902 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | DATE
2/10 | | 20c. LOCATION — City or Town, State
Denton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph P. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A.
Drawer B, Denton, Maryland 21629 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Respiratory failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>acute pulmonary edema</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 4 days |
| | | c. <i>coronary artery disease</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 1/15 |
| | | d. <i>arteriosclerotic cardiovascular disease</i> | | | | | 4/15 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Recent urinary tract infection</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Albert Dawkins MD.</i> | | | | 29c. LICENSE NUMBER
D02824 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Albert Dawkins MD. 508 Idlewild Ave. Easton Md. 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 08 '95 | | 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06762

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM FREEMAN JONES | | | | 2. DATE OF DEATH
MONTH 2 DAY 10 YEAR 95 | | 3. TIME OF DEATH
7; 40 AM | |
| 4. SOCIAL SECURITY NUMBER
212-16-1688 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1 30 15 | |
| 9a. FACILITY NAME (If not institution, give street and number)
1718 WILSON LANE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
MD. | | | | 10b. COUNTY
WICOMICO | | 10c. CITY, TOWN OR LOCATION
SALISBURY | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
1718 WILSON LANE | | | | 10f. ZIP CODE
21801 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
RET. EMPLOYEE BY-PRODUCTS | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LINCOLN JONES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
JENNY PRICE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
GERTRUDE JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ADDRESS SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ST. JAMES FREE METHODIST | | DATE
2-17 | | 20c. LOCATION — City or Town, State
HEAD-OF-THE-CREEK, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Loretta B. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY
JOLLEY MEMORIAL CHAPEL, 1213 JERSEY ROAD,
SALISBURY, MD. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cancer Prostate</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
<i>NA</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER
D34976 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
#16 Medical Center Salo md 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #206. 2/17/95 Edm. P.G.

95 06763

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Albert Jones</u> | | | | 2. DATE OF DEATH
MONTH <u>Feb</u> DAY <u>15</u> YEAR <u>95</u> | | | | 3. TIME OF DEATH
<u>0510 A M</u> | | | | |
| 4. SOCIAL SECURITY NUMBER
<u>578-56-3722A</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<u>52</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS.
HOURS <u> </u> MIN. <u> </u> | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>11-10-42</u> | | 8. BIRTHPLACE (State or Foreign Country)
<u>Wash. D.C.</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>WASHINGTON ADVENTIST HOSPITAL</u> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>TAKOMA PARK</u> | | | | 9c. COUNTY OF DEATH
<u>MONTGOMERY</u> | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Prince George's</u> | | | 10c. CITY, TOWN OR LOCATION
<u>Hyattsville</u> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
<u>6500 Riggs Road</u> | | | | | 10f. ZIP CODE
<u>20783</u> | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>Black</u> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u> </u> College (1-4 or 5+) <u>2</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Supervisor</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Private</u> | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Joseph Jones</u> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Virginia Portal</u> | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Carolyn E. St. Hill</u> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>8025 Carey Branch Pl., Ft. Wash., Md.</u> | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Mt. Olivet Ceme. 2/20/95</u> | | | | 20c. LOCATION — City or Town, State
<u>Washington, D.C.</u> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>John T. Stewart III</u> | | | | | | 22. NAME AND ADDRESS OF FACILITY
<u>STEWART FUNERAL HOME</u>
<u>4001 Benning Rd. N.E., Wash. D.C.</u> | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>acquired immune deficiency syndrome</u>
Approximate interval between Onset and Death <u>unk</u>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):
b. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):
c. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):
d. <u> </u> | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Primary chronic lung disease</u>
<u>Prior history of chest pain</u>
<u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></u> | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>John T. Stewart III</u> | | | | | | 29c. LICENSE NUMBER
<u>D01497</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>FEB. 15, 95</u> | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>6201 Greenbelt Rd. College Pk. Md. 20740</u> | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>FEB 17 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06764

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM JOSEPH JONES | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 16, 1995 | | 3. TIME OF DEATH
M
06:10 | |
| 4. SOCIAL SECURITY NUMBER
577 36 1794 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 6, 1930 | |
| 9a. FACILITY NAME (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
PRINCE FREDERICK | | 9c. COUNTY OF DEATH
CALVERT | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Port Republic | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4006 South Shore Drive | | | |
| 10f. ZIP CODE
20676 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (8-12) 12
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Brick Mason | | 16b. KIND OF BUSINESS/INDUSTRY
Union Local 1 | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George E. Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marjorie M. Mundell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dolores C. Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4006 South Shore Drive Port Republic Md. 20676 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 2/20/95 | | 20c. LOCATION — City or Town, State
Clinton Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans | |
| 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Uremia
DUE TO (OR AS A CONSEQUENCE OF):
c. end stage renal disease
DUE TO (OR AS A CONSEQUENCE OF):
d. diabetes mellitus | | | | | | | Approximate Interval Between Onset and Death
10 days
18 months
15 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
peritonitis
coronary artery disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Harold Home MD | | | | 29c. LICENSE NUMBER
D44618 | | 29d. DATE SIGNED (Month, Day, Year)
2/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
120 Hospital Rd Suite 200 Prince Frederick MD 20678 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06765

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Garrett DeVictor Jones | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 3, 1995 | | 3. TIME OF DEATH
4:50 a. M | |
| 4. SOCIAL SECURITY NUMBER
219-03-8859 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Oct 22, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Moran Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Westernport | | 9c. COUNTY OF DEATH
Allegany | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
428 Grand Avenue | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
machinist | | 16b. KIND OF BUSINESS/INDUSTRY
railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edwin Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bertha Frances Brooks | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jean Tracy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12113 Marigold Street SW; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | DATE
02/06 | | 20c. LOCATION — City or Town, State
Flintstone, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James F. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
5 minutes
UNKNOWN |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PROSTATE CARCINOMA WITH EXTENSIVE BONE METASTASIS
CHRONIC OBSTRUCTIVE LUNG DISEASE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Chang M.D.</i> | | | | 29c. LICENSE NUMBER
D25638 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 10 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Saturnina Chang, M.D.; Route 36 Frostburg Plaza; Frostburg, MD 21532 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06766

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JACK EMERSON JONES | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 13, 1995 | | 3. TIME OF DEATH
8:06 P M | |
| 4. SOCIAL SECURITY NUMBER
215-26-6299 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sep 26, 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MD | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
701 Patterson Avenue | | | |
| 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Retired | | 16b. KIND OF BUSINESS/INDUSTRY
Tire Company | |
| 17. FATHER'S NAME (First, Middle, Last)
Lewis F. Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie G. (Stewart) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Helen Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
701 Patterson Avenue; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Smithsburg Crematorium 02/20 | | 20c. LOCATION — City or Town, State
Smithsburg, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jones & Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. INTRACTABLE HYPOTENSION
DUE TO (OR AS A CONSEQUENCE OF):
b. ELECTROMECHANICAL CARDIAC DYSFUNCTION
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death
5min
8min |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END STAGE KIDNEY DISEASE, KIDNEY OSTEOHYSTROPHY
PERIPHERAL VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Robert Welik</i> | | | | 29c. LICENSE NUMBER
D31075 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 13, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert Welik MD, 902 Seton Drive Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06767

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lawrence Jerome James | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 17, 1995 | | 3. TIME OF DEATH
9:50 p.m. | | |
| 4. SOCIAL SECURITY NUMBER
215- 12-7933 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 16, 1923 | | |
| 9a. FACILITY NAME (If not institution, give street and number)
4735 Harney Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Taneytown | | 9c. COUNTY OF DEATH
Carroll | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Carroll | | 10c. CITY, TOWN OR LOCATION
Taneytown | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER
4735 Harney Road | | | | 10f. ZIP CODE
21787 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Caucasian | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Millwright | | 16b. KIND OF BUSINESS/INDUSTRY
Utilities-County Govt. | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
David James | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie Thater | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Flora S. James | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4735 Harney Road, Taneytown, MD 21787 | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Cemetery | | DATE
2/21 | | 20c. LOCATION — City or Town, State
Gettysburg, PA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
John M. Skiles | | | | 22. NAME AND ADDRESS OF FACILITY
Skiles Funeral Home
136 E. Baltimore St., Taneytown, MD 21787 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Acute renal failure
Dehydration
Lung Carcinoma
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Congestive heart failure, Peptic Ulcer disease | | | | | | | Approximate Interval Between Onset and Death
1 week
3-4 day
~2 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure, Peptic Ulcer disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
C. M. Skiles | | | | 29c. LICENSE NUMBER
MD027200E | | 29d. DATE SIGNED (Month, Day, Year)
2-18-95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Orville McBeth, 3375 Carlisle Rd, Carders, Pa. 17324 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FLA

641 B00610



95 06768

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary D. Kerr | | | | 2. DATE OF DEATH
MONTH February DAY 16 YEAR 1995 | | 3. TIME OF DEATH
2:12 P M | |
| 4. SOCIAL SECURITY NUMBER
208-46-6738 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
103 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-11-1891 | |
| 8. BIRTHPLACE (State or Foreign Country)
PA. | | | | 9a. FACILITY NAME (If not institution, give street and number)
BERLIN NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | |
| 9c. COUNTY OF DEATH
WORCESTER | | | | 10a. STATE
MD. | | 10b. COUNTY
WORCESTER | |
| 10c. CITY, TOWN OR LOCATION
BERLIN | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
119 TEAL CIRCLE | |
| 10f. ZIP CODE
21811 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
CLARK CRAIG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SARAH TRAISTER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ELVA ZENK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1723 OCEAN PINES BERLIN, MD., 21811 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE
NEW BETHLEHEM CEM. 2-20 | | 20c. LOCATION — City or Town, State
NEW BETHLEHEM, PA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
ULLRICH FUNERAL HOME BERLIN, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Generalized Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
Septic Ulcer Disease
G.I. Bleeding. Anemia
Gastric Outlet Obstruction | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D 29505 | | 29d. DATE SIGNED (Month, Day, Year)
2-16-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GREGORIO M. BELLOSO. 4421 BEECHWOOD PL., CRISFIELD MD 21817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FLORENCE KELLEY

95 06769

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Florence E. Kelley</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>Feb. 7, 1995</i> | | 3. TIME OF DEATH
11:08 A M | |
| 4. SOCIAL SECURITY NUMBER
<i>219-05-3241</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In years last birthday)
<i>94</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Sept 16, 1900</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Va.</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>SALISBURY Nursing & Rehab Center</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Salisbury, Md. 21801</i> | |
| 9c. COUNTY OF DEATH
<i>WICOMICO</i> | | | | 10a. STATE
<i>md.</i> | | 10b. COUNTY
<i>Wicomico</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Salisbury</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>211 Glenn Ave</i> | |
| 10f. ZIP CODE
<i>21801</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>7th</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Domestic</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>laborer</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>William Holden</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Maggie Wise</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Lillian K. Reed</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>211 Glenn Ave Salisbury, md. 21801</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Green Acres Cemetery 2/12</i> | | 20c. LOCATION — City or Town, State
<i>Salisbury, md. 21801</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>LEWIS W. WATSON FUNERAL HOME
1618 West Rd. Salisbury, md. 21801</i> | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>a. Sepsis, Source Unknown</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>b. Persistent Vegetative State</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>c. Advanced Alzheimer's Disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>d.</i> | | Approximate Interval Between Onset and Death
<i>1 week</i> | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Long Vascular Disease, Cancer, S/P regulation heart</i> | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
<i></i> | |
| 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
<i></i> | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<i></i> | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<i></i> | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
<i>D-39813</i> | |
| 29d. DATE SIGNED (Month, Day, Year)
<i>2/7/95</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>DR. MICHAEL ATKINS, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801</i> | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 14 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06770

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Donald L. Kight | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 20 1995 | | 3. TIME OF DEATH
11:30 A M | |
| 4. SOCIAL SECURITY NUMBER
215-05-9422 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Apr 23, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
University of Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
None | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Catonsville | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
3 Rumford Drive Apt 202 | | | | 10f. ZIP CODE
21228 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Self Employed | | 15b. KIND OF BUSINESS/INDUSTRY
Insurance Agency | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph L. Kight | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Hallie Barrick | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Charlotte Kight | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Rumford Drive Apt 202 Catonsville, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Crestlawn Cemetery Feb 24 | | 20c. LOCATION — City or Town, State
Marriottsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stephen Lee</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc
4112 Old Columbia Pike Ellicott City 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiogenic Shock</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Congestive Heart Failure</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u>Acute Myocardial Infarction</u>
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Multiple Pelvic Fractures</u>
<u>Pelvic Hematoma</u> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2/18/95 | | 28b. TIME OF INJURY
1320H | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED
<u>subject struck by vehicle</u> | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<u>roadway</u> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<u>Witzke Funeral Home parking lot</u> | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William C. Chin M.D.</i> | | | | 29c. LICENSE NUMBER
D 46147 | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>William C. Chin M.D., R Adams Cowley Shock Trauma Center</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane A. Hunsicker-Hardall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED FROM BOND

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSEPH KIM | | | | 2. DATE OF DEATH
MONTH FEB DAY 24 YEAR 95 | | 3. TIME OF DEATH
11:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER
063-14-6765 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
FEB 13 01 | |
| 9a. FACILITY NAME (If not institution, give street and number)
1580 Marco Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Pasadena | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Pasadena | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1580 Marco Drive | | | | 10f. ZIP CODE
21122 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Korean | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Retouch Artist | | 16b. KIND OF BUSINESS/INDUSTRY
Photography | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Yun Kook Kim | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Okasan | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Boris Kim | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1580 Marco Drive Pasadena, Maryland 21122 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Emmanuel U.M.C. Cemetery | | DATE
2/27 | | 20c. LOCATION — City or Town, State
Scaggsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gregg S. Kap... | | | | 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home P.A.
313 Talbott Avenue Laurel, Maryland 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death
5 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
William Flowers MD | | | | | |
| | | 29c. LICENSE NUMBER
D20708 | | 29d. DATE SIGNED (Month, Day, Year)
2/25/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Flowers MD 11055 Little Patuxent Columbia | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 27 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Robell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
ROBERT KREIDER | | | 2. DATE OF DEATH
MONTH 2 DAY 20 YEAR 95 | | | 3. TIME OF DEATH
3:30A. | | | | | | |
| 4. SOCIAL SECURITY NUMBER
216-01-7799 | | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 18, 1909 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Carroll County General Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Westminster | | | 9c. COUNTY OF DEATH
Carroll | | | |
| RESIDENCE OF DECEASED | | | | | | | | | | | | |
| 10a. STATE
Maryland | | | 10b. COUNTY
Cecil | | | 10c. CITY, TOWN OR LOCATION
Perryville | | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | | | |
| 10e. STREET AND NUMBER
635 Franklin Street | | | | | | 10f. ZIP CODE
21903 | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
3 Widowed 4 Divorced | | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEASED'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) ----- College (1-4 or 5+) Two Years | | | | | | 16a. DECEASED'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Budget Analyst | | | 16b. KIND OF BUSINESS/INDUSTRY
Aberdeen Proving Ground
Aberdeen, Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John L. Kreider | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sara E. Smith | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert W. Kreider, Jr. | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1000 Charlene Drive, Sykesville, Maryland 21784 | | | | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Spesutia Cemetery 2/22/95 | | | 20c. LOCATION — City or Town, State
Perryman, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert J. Patterson, Jr. | | | | | | 22. NAME AND ADDRESS OF FACILITY
Lee A. Patterson & Son Funeral Home
Perryville, Maryland 21903 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. POSSIBLE SEPTICAEMIA.
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate interval between Onset and Death
5 HRS. | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NIDDM, BIPOLAR DISORDER | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide 4 Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Hafeez A Syed M.D. | | | 29c. LICENSE NUMBER
D25052 | | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HAEEZ A SYED, 20 Cross Roads Dr, Owings Mills 21117 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | 32. REGISTRAR'S SIGNATURE
John Anderson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 06773

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Mary Leona Long</i> | | | | 2. DATE OF DEATH
MONTH <i>2</i> DAY <i>15</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>0040 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>217-22-0138</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
<i>87</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Jun 18, 1907</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>St. Mary's Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Leonardtown</i> | | 9c. COUNTY OF DEATH
<i>St. Mary's</i> | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>St. Mary's</i> | | 10c. CITY, TOWN OR LOCATION
<i>Leonardtown</i> | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
<i>Cedar Lane Apartments</i> | | | | 10f. ZIP CODE
<i>20650</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<i>Elementary/Secondary (9-12)</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Thomas Vinton Harding</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Bernice Hayden</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Doris A. Wood</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3920 New Market Turner Rd., Mechanicsville MD 20659</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>St. Joseph's Cemetery</i> | | 20c. LOCATION — City or Town, State
<i>2/17/95 Morganza, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Uro sepsis</i>
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. <i>Uro sepsis</i>
DUE TO (OR AS A CONSEQUENCE OF):

b.
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death
<i>1 day</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Probable cerebrovascular Accident</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David Allen</i> | | | | 29c. LICENSE NUMBER
<i>D 25230</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2/16/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print)
<i>David Allen, M.D. Leonardtown, Maryland 20650</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 17 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Wilson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06774

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kathleen Frances Lacey | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 15, 1995 | | 3. TIME OF DEATH
11:45 AM | |
| 4. SOCIAL SECURITY NUMBER
317-01-9854 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Sep 6, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Bayside Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lexington Park | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Leonardtown | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
Rt. 1 Box 141 | | | | 10f. ZIP CODE
20650 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12th Grade | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Owner/Operator | | 16b. KIND OF BUSINESS/INDUSTRY
Cosmetology School | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John M. Holmes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lula Myrtle Berge | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph E. Lacey, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 141, Leonardtown, MD 20650 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 2/18/95 | | 20c. LOCATION — City or Town, State
Leonardtown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael H. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Multiple sclerosis
DUE TO (OR AS A CONSEQUENCE OF):
f. Dementia
DUE TO (OR AS A CONSEQUENCE OF):
g. _____
DUE TO (OR AS A CONSEQUENCE OF):
h. _____
DUE TO (OR AS A CONSEQUENCE OF):
i. _____
DUE TO (OR AS A CONSEQUENCE OF):
j. _____
DUE TO (OR AS A CONSEQUENCE OF):
k. _____
DUE TO (OR AS A CONSEQUENCE OF):
l. _____
DUE TO (OR AS A CONSEQUENCE OF):
m. _____
DUE TO (OR AS A CONSEQUENCE OF):
n. _____
DUE TO (OR AS A CONSEQUENCE OF):
o. _____
DUE TO (OR AS A CONSEQUENCE OF):
p. _____
DUE TO (OR AS A CONSEQUENCE OF):
q. _____
DUE TO (OR AS A CONSEQUENCE OF):
r. _____
DUE TO (OR AS A CONSEQUENCE OF):
s. _____
DUE TO (OR AS A CONSEQUENCE OF):
t. _____
DUE TO (OR AS A CONSEQUENCE OF):
u. _____
DUE TO (OR AS A CONSEQUENCE OF):
v. _____
DUE TO (OR AS A CONSEQUENCE OF):
w. _____
DUE TO (OR AS A CONSEQUENCE OF):
x. _____
DUE TO (OR AS A CONSEQUENCE OF):
y. _____
DUE TO (OR AS A CONSEQUENCE OF):
z. _____
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
8 yrs +
8 yrs + |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
_____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>B. J. H.</i> | | | | 29c. LICENSE NUMBER
D33470 | | 29d. DATE SIGNED (Month, Day, Year)
2/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bhasker Jhaveri, M.D. Shanti Medical Center, Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06775

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Margaret Lee | | | | 2. DATE OF DEATH
MONTH Feb DAY 1 YEAR 95 | | | | 3. TIME OF DEATH
9:55 A | |
| 4. SOCIAL SECURITY NUMBER
578-10-4092 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 16, 1916 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Sacred Heart Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
University Park | | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4204 Clagett Road | | 10f. ZIP CODE
20782 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 1 yr. | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Administrative Assistant | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Gonsalvo | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Virginia Josephine Gibson | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Lee McCleary | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 333, Clarkville, MD 21029 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Sacred Heart Cemetery 2/4/95 | | 20c. LOCATION — City or Town, State
Bushwood, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Ischemic Bowel
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Dementia
Arthritis | | | | Approximate Interval Between Onset and Death

12 hrs | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Arthritis | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Stephanie Trifoglio MD</i> | | 29c. LICENSE NUMBER
D37934 | | 29d. DATE SIGNED (Month, Day, Year)
2/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stephanie Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20770 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

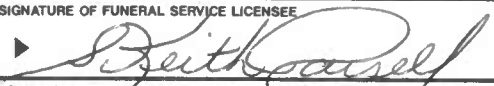

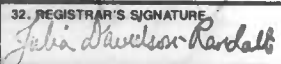
95 06776

Amended Item # 28a WCHD 2/24/95 jrd Amended Item #11 WCHD 2/27/95 mpt

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Donald Lynch, Jr. | | | | 2. DATE OF DEATH
MONTH 02 DAY 08 YEAR 95 | | 3. TIME OF DEATH
0915 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
221-62-0952 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
26 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5-05-68 | | 8. BIRTHPLACE (State or Foreign Country)
Delaware | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Peninsula Regional Medical Ctr | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Salisbury | | | | 9c. COUNTY OF DEATH
Wicomico | | | |
| 10a. STATE
Delaware | | 10b. COUNTY
Sussex | | 10c. CITY, TOWN OR LOCATION
Lewes | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
Box 158, Donovans/Smith Mobile Home Park | | | | 10f. ZIP CODE
19958 | | 10g. CITIZEN OF WHAT COUNTRY?
United States of America | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Fitness Instructor | | 18b. KIND OF BUSINESS/INDUSTRY
YMCA | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Donald S. Lynch, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Susie K. Iwata | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Susie K. Lynch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 158, Donovan/Smith Mobile Home Park, Lewes, DE 19958 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Bethel Methodist Cemetery | | OATE
2/11/95 | | 20c. LOCATION — City or Town, State
Lewes, Delaware | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Parsell Atkins & Lodge Funeral Home
P.O. Box 477 RT 1, Lewes, DE 19958 | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Closed Head Injury
DUE TO (OR AS A CONSEQUENCE OF):
b. Auto Accident
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
9 days | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL:
1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA | | 26. PLACE OF DEATH (Check only one)
OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
01-12-29-95 | | 28b. TIME OF INJURY
Unknown | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Auto struck tree | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Delaware Route 24 | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Lewes, Delaware | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 D.M.E. | | | | 29c. LICENSE NUMBER
D03599 | | 29d. DATE SIGNED (Month, Day, Year)
02-08-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John T. Bulkeley M.D., 108 Pine Bluff Rd, Salisbury, Md. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95-645-033

asp

95 06777

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
HENRY LITTLE 3rd | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 06 1995 | | 3. TIME OF DEATH
2:25 P M | |
| 4. SOCIAL SECURITY NUMBER
578-86-1314 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
12-15-58 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash. D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
600 OPUS AVE | | 9b. CITY, TOWN OR LOCATION OF DEATH
CAPITOL HEIGHTS | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Capitol Heights | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
600 Opus Avenue | |
| 10f. ZIP CODE
20743 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
U.S. Postal Service | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Little, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lorraine McDowell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Vondell B. Little | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
815 Clovis Ave. Cap. Hghts., Md. | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Md. Nat. Mem. Park Ceme. 2/13/95 Laurel, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart, III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME
4001 Benning Rd. N.E., Wash. D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intra-Ora! Shotgun Wound
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year)
Found 2-6-95 | | 28b. TIME OF INJURY
1334 M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
self-inflicted shotgun wound | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
600 Opus Ave Capitol Heights MD | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Devin J. Chute MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB 07, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Lucas, Paul

95 06778

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last)
PAUL SIDNEY LUCAS | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 8 YEAR 1995 | | 3. TIME OF DEATH
12:15 P | | | | | |
| 4. SOCIAL SECURITY NUMBER
577-70-1107 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
44 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH
(Month, Day, Year)
11/03/50 | | 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | | 9c. COUNTY OF DEATH
PG | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Washington, D.C. | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
524 First Street, S.E. | | | | 10f. ZIP CODE
20032 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Construction Worker | | | 16b. KIND OF BUSINESS/INDUSTRY
Flippo Construction Co. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Harold P. Lucas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sereta Hogue-Lucas | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Adrienne Lucas/sister | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
524 First St., S.E. Washington, D.C. 20032 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glenwood Cemetery | | DATE | | 20c. LOCATION — City or Town, State
Wash., DC | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> #866 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert G. Mason Funeral Home, Inc.
1661 Good Hope Road, SE Wash., DC 20020 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Pneumonia
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
AIDS | | | | | | | | Approximate Interval Between Onset and Death
4 days
1 year | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AIDS Dementia - Decubitus ulcers | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Sam T. [Signature] | | | | 29c. LICENSE NUMBER
D34274 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 9, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ESSAM TELLAWI, M.D. 7700 OLD BRANCH AVENUE, CLINTON, MARYLAND 20735 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | |

95 06779

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SARAH LILLIAN LEWIS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 16, 1995 | | 3. TIME OF DEATH
01:10 A^M | |
| 4. SOCIAL SECURITY NUMBER
214-05-9772 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCTOBER 24 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
ALLEGANY | | 10c. CITY, TOWN OR LOCATION
CUMBERLAND | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
12807 WINCHESTER ROAD | | | |
| 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U S A | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) -- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHN FREDERICK WADE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LILLIE GERLACH | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DONALD L. LEWIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2887 BALTIMORE PIKE GETTYSBURG, PA 17325 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FROSTBURG MEMORIAL PK FEB | | 20c. LOCATION — City or Town, State
FROSTBURG, MD | | 20d. DATE
FEB | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Douglas A. Hafner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HAFER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY LAVALE, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. DIASTOLIC DYSFUNCTION (CARDIAC)
DUE TO (OR AS A CONSEQUENCE OF):
d. HYPERTROPHIC CARDIOMYOPATHY | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL FIBRILLATION, RESTRICTIVE LUNG DISEASE, HYPOTHYROIDISM, PACEMAKER. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Wally S. Hibbs, MD</i> | | | | 29c. LICENSE NUMBER
D11925 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 16, 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
WALLY S. HIBBS, MD 909A SEFON DR, CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06780

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DAVID LESLIE LEESE | | | | 2. DATE OF DEATH
MONTH Feb. DAY 12 , YEAR 1995 | | 3. TIME OF DEATH
3:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER
215-68-6070 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug 6, 1954 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Alt. Route 40 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LaVale | | 9c. COUNTY OF DEATH
Allegany | |
| 10a. STATE
MD | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
LaVale | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
10 Vocke Drive | | | |
| 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Refrigeration Mechanic | | 15b. KIND OF BUSINESS/INDUSTRY
Paper Mill | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Delbert C. Leese, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Martha J. (Fratz) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kelly L. Leese | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Vocke Drive; LaVale, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Zion Lutheran Church Cem. 02/16 | | 20c. LOCATION — City or Town, State
Accident, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
James F. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → self inflicted gunshot wound to head

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
instant | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
depression | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) roadside park | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
Feb 12, 1995 | | 28b. TIME OF INJURY
3:00P.M. | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
self inflicted gunshot wound | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
roadside park | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Alt Rte. 40 West of
Continental Hotel | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Donald Manger | | | | 29c. LICENSE NUMBER
D09231 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 15 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Donald Manger Rte. 2 Box 828 Hazen Rd; Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06781

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MILDRED LAURENZI | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 13, 1995 | | 3. TIME OF DEATH
4:45AM M | |
| 4. SOCIAL SECURITY NUMBER
579-50-8506
578-22-7600 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 22, 1928 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
Prince George Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
P.G. | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Capitol Heights | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
312 Rollins Ave | | | | 10f. ZIP CODE
20743 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Ernest Joseph Burroughs, Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Dorothy E. Seis | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles Laurenzi | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
312 Rollins Ave, Capitol Heights, MD 20743 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cem. Feb 17, 1995 | | DATE
Feb 17, 1995 | | 20c. LOCATION — City or Town, State
Cheltenham, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles L. Belanger | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc 6633
old Alexander Ferry Road, Clinton, MD 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Abdominal Corrosion
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Frederick H Wilhelm MD | | | | 29c. LICENSE NUMBER
D 10220 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Frederick H Wilhelm MD 5807 Annapolis Road H+Hville, Maryland 20784 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Shuster-Rodall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06782

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary A. Lonsbury | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 16 1995 | | 3. TIME OF DEATH
1:10P.M. | | |
| 4. SOCIAL SECURITY NUMBER
471 68 8245 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 30, 1908 | | |
| 9a. FACILITY NAME (If not institution, give street and number)
7009 Bluebird Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | 9c. COUNTY OF DEATH
Prince George's | | |
| 10a. STATE
Minnesota | | | | 10b. COUNTY
Hennepin | | 10c. CITY, TOWN OR LOCATION
Edina | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER
4401 Parklawn Ave. | | | | 10f. ZIP CODE
55435 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last)
August Oelke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Louisa Ganz | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marilyn Drake | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7009 Bluebird Court Lanham Md. 20706 | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. LOCATION — City or Town, State
Alexandria Virginia | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans, Pres. | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → End stage heart failure
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Non Q wave Myocardial infarction.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | Approximate interval Between Onset and Death | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Routan Farahi M.D. | | | | |
| 29c. LICENSE NUMBER
D43446 | | | | 29d. DATE SIGNED (Month, Day, Year)
2/17/95 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ROINTAN FARAH-FAR, M.D. 4000 Mitchellville road #B216 Bowie MD 20716 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.



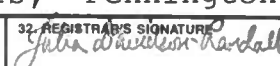
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06783

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BEULAH M. LAMBDIN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 12 1995 | | 3. TIME OF DEATH
01:39 A.M. | |
| 4. SOCIAL SECURITY NUMBER
222-05-7850 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-1-1911 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Union Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Elkton | | 9c. COUNTY OF DEATH
Cecil | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Delaware | | 10b. COUNTY
New Castle | | 10c. CITY, TOWN OR LOCATION
Townsend | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
896 Blackbird Station Rd. | | | | 10f. ZIP CODE
19734 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (13-16 or 17+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Homemaker | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Braden A. McGinnis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Dora Belle Cottle | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Norman Lambdin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
896 Blackbird Station Rd., Townsend, De. 19734 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Townsend Cemetery 2-15-95 Townsend, Delaware | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
DANIELS & HUTCHISON
212 N. Broad St., Middletown, De. 19709 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>acute myocardial infarction</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <u>hypertensive cardiovascular disease</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
CI-0001534 | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Kenneth Lewis, Pennington Street, Middletown, De. 19709 | | | | | | | |
| 31. DATE FILED
FEB 13 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06784

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Marvin W. McGoogan | | | | 2. DATE OF DEATH
MONTH 2 DAY 14 YEAR 95 | | 3. TIME OF DEATH
2255 M | |
| 4. SOCIAL SECURITY NUMBER
256-20-5524 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-12-26 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Peninsula Regional Medical Ctr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Salisbury | | 9c. COUNTY OF DEATH
Wicomico | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Pocomoke City | |
| 10d. INSIDE CITY LIMITS?
1 YES 2 NO | | | | 10e. STREET AND NUMBER
305 Winterquarters Drive | | | |
| 10f. ZIP CODE
21851 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 YES 2 NO
IF YES, GIVE WAR OR DATES
WWII ARMY/AIRFORCE | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: no | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Electrical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
NASA | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Bruce McGooogan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ella Mae Tomlinson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Louise McGoogan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 Winterquarters Dr., Pocomoke, Md. 21851 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Pitts Creek Presbyterian Cemetery 2/17 Pocomoke City, Maryland | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Scott S. Melson | | | | 22. NAME AND ADDRESS OF FACILITY
Melson Funeral Home
PO Box 64, Pocomoke City, Md. 21851 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John T. Bulkeley, M.D., M.E. | | | | 29c. LICENSE NUMBER
D03599 | | 29d. DATE SIGNED (Month, Day, Year)
2-15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John T. Bulkeley, M.D. 108 Pine Bluff Rd. Salisbury, Md 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
John T. Bulkeley | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06785

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Beatrice Skoglund Maney | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 7, 1995 | | | | 3. TIME OF DEATH
0304 A. M. | |
| 4. SOCIAL SECURITY NUMBER
324-12-9524 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
75 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
April 15, 1919 | | 8. BIRTHPLACE (State or Foreign Country)
Illinois | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Lexington Park | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6C Eric Road | | | | 10f. ZIP CODE
20653 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Sales Person | | 16b. KIND OF BUSINESS/INDUSTRY
Retail Clothing | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Armond Skoglund | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elfreda Ostwald | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sandra M. Hill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6c Eric Road, Lexington Park, Maryland 20653 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 2-9-95 | | 20c. LOCATION — City or Town, State
Virginia | | | | | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE
<i>Edward N. Brinsfield, Jr.</i> M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): <i>C.V.A.</i>

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
<i>W/1</i> | | 28b. TIME OF INJURY
<i>11A</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
<i>VIA</i> | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William D. Boyd II, M.D.</i> | | 29c. LICENSE NUMBER
<i>D14285</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2-7-95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William D. Boyd II, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 10 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET ALICE MILBURN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 8, 1995 | | 3. TIME OF DEATH
2:40 P.M. | |
| 4. SOCIAL SECURITY NUMBER
219-46-9531 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
67 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Apr 6, 1927 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not Institution, give street and number)
ST. MARY'S HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LEONARDTOWN | | 9c. COUNTY OF DEATH
ST. MARY'S | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Lexington Park | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
410 ERICKSON CT. | | | | 10f. ZIP CODE
20653 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+)
6th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housekeeper | | 16b. KIND OF BUSINESS/INDUSTRY
Private Homes | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Holton Briscoe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catherine Alberta Briscoe | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James F. Milburn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
410 Erickson Ct., Lexington Park, MD 20653 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Georges Catholic Cem 2/14/95 | | 20c. LOCATION — City or Town, State
Valley Lee, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael J. Lindner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
s. <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
AND <u>CHRONIC RENAL FAILURE</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>DIABETES MELLITUS</u> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> VER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER
<i>John F. Goh...</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB 9, 1995 | |
| 31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MRB F. Goh, Jr MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 10 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John F. Goh...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06787

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
STEVENSON RICHIE McKNIGHT, JR. | | | 2. DATE OF DEATH
MONTH DAY YEAR
JANUARY 25, 1995 | | 3. TIME OF DEATH
M |
| 4. SOCIAL SECURITY NUMBER
218-94-2062 | 5. SEX
XX M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
24 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
MARCH 15, 1970 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number)
3719 Rt. 50 PO. BOX 114 | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LINKWOOD | | 9c. COUNTY OF DEATH
DORCHESTER |
| 10a. STATE
MARYLAND | | | 10b. COUNTY
DORCHESTER | | 10c. CITY, TOWN OR LOCATION
LINKWOOD |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 10e. STREET AND NUMBER
3719 RT. 50 P.O. BOX 114 | | |
| 10f. ZIP CODE
21631 | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER | |
| 16b. KIND OF BUSINESS/INDUSTRY
FARMING | | 17. FATHER'S NAME (First, Middle, Last)
STEVENSON RICHIE McKNIGHT, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MAE E. McKNIGHT | |
| 19a. INFORMANT'S NAME (Type/Print)
MARY PINDER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 114, LINKWOOD, MD. 21835 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SALEM CEMETERY JAN. 28, 95 SALEM, MD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY
BENNIE SMITH FUNERAL SERVICES
P.O. BOX 1687, EASTON, MD. 21601 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aids - End Stage CD4-1
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
acute Renal failure
Dilated Cardiomyopathy
Recurrent Pneumonia | | | | | Approximate Interval Between Onset and Death
72yrs
23mos
23yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cocaine addiction | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Judy C. Washington MD | | 29c. LICENSE NUMBER
D31108 | | 29d. DATE SIGNED (Month, Day, Year)
1/30/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Judy C. Washington MD #108 Bay Street Cambridge MD 21613 | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 02 '95 | | 32. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE LUCH BOND

ALION 1000

[Faint, illegible handwriting in the left margin, possibly bleed-through from the reverse side.]

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95 06788

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
KATHLEEN RITA MAHONEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 9, 1995 | | 3. TIME OF DEATH
2:55 P M | |
| 4. SOCIAL SECURITY NUMBER
579-10-2871 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 30, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
Carroll Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
4922 LaSalle Road | |
| 10f. ZIP CODE
20782 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Telephone Operator | | 16b. KIND OF BUSINESS/INDUSTRY
United States Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Mahoney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Spicer | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dianna Mahoney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1806 Montreal Road, Severn, Maryland 21144 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 02/10/95 | | 20c. LOCATION — City or Town, State
Alexandria, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W.B. Gieser | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Cardiac Arrest
b. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus, Multiple Sclerosis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
C.A. Cefaw | | | | 29c. LICENSE NUMBER
D43442 | | 29d. DATE SIGNED (Month, Day, Year)
2/10/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
C.A. Cefaw 4151 Bladensburg Rd ColMAR, MD 20722 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06789

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Sarah A. Martin | | | | 2. DATE OF DEATH
MONTH DAY YEAR
02-14-95 | | 3. TIME OF DEATH
12:35 A.M. | |
| 4. SOCIAL SECURITY NUMBER
411-42-5327 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
05-24-31 | |
| 8. BIRTHPLACE (State or Foreign Country)
Tennessee | | | | 9a. FACILITY NAME (If not institution, give street and number)
12001 Cook Court | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | |
| 10c. CITY, TOWN OR LOCATION
Silver Spring | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
12001 Cook Court | |
| 10f. ZIP CODE
20902 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9
College (13-16) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Waitress - Cook | | 16b. KIND OF BUSINESS/INDUSTRY
Private | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lawrence Hicks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sarah Franey | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Patricia Thomas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12001 Cook Court, Silver Spring, Md. 20902 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington Nat'l. Ceme. 2/18/95 Suitland, Md. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart, III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME
4001 Benning Road N.E., Wash. D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Cervical Cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Frederick A. Barr, M.D.</i> | | | | 29c. LICENSE NUMBER
D22775 | | 29d. DATE SIGNED (Month, Day, Year)
2-15-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Frederick Barr, M.D. 106 Irving Street N.W., Washington, D.C. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia D. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06790

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BETTY I. MOYLAN | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 11 YEAR 1995 | | | | 3. TIME OF DEATH
11:00 A M | |
| 4. SOCIAL SECURITY NUMBER
577 32 6528 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 27, 1927 | | 8. BIRTHPLACE (State or Foreign Country)
Washington D.C. | |
| 9a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park | | | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Bowie | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2504 Kevin Lane | | | | 10f. ZIP CODE
20715 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Billing Investigation | | 16b. KIND OF BUSINESS/INDUSTRY
C & P Telephone | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Stephen Goldsborough | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gertrude Norbeck | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Vincent J. Moylan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2504 Kevin Lane Bowie Maryland 20715 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | DATE 2/15/95 | | 20c. LOCATION — City or Town, State
Cheltenham Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans, Pres | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Road Bowie Maryland 20715 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → BRONCHIOALVEOLAR CARCINOMA OF RIGHT LUNG
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. 15 YEARS | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James A. Brown, MD | | | | 29c. LICENSE NUMBER
D07285 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 11, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAMES A. BROWN MD 9709 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
John A. Brown | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06791

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Caroline Neal Mandrich | | | | 2. DATE OF DEATH
MONTH 2 DAY 13 YEAR 95 | | 3. TIME OF DEATH
13:30 M | |
| 4. SOCIAL SECURITY NUMBER
266 47 1567 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 14, 1959 | |
| 8. BIRTHPLACE (State or Foreign Country)
California | | 9a. FACILITY NAME (If not institution, give street and number)
Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Annapolis | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Bowie | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
12421 Chalford Lane | | | | 10f. ZIP CODE
20715 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Education | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Donald A. Neal | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Virginia Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nicholas D. Mandrich Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12421 Chalford Lane Bowie Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens 2/16/95 | | 20c. LOCATION — City or Town, State
Davidsonville Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans Pres. | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRAL HEMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
12h |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
NONE | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] MD | | 29c. LICENSE NUMBER
D13213 | | 29d. DATE SIGNED (Month, Day, Year)
1/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PETER SCHILDER 600 RIDGELY AVE ANNAPOLIS | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100% COTTON

100% COTTON

100% COTTON



95 06792

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELIZABETH KATHRYN | | | | 2. DATE OF DEATH
MONTH FEB DAY 15 YEAR 1995 | | | | 3. TIME OF DEATH
0212 A | |
| 4. SOCIAL SECURITY NUMBER
214-07-4257 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Mar 28, 1913 | | 8. BIRTHPLACE (State or Foreign Country)
MD | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | | 9c. COUNTY OF DEATH
WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Berlin | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9142 Old Ocean City Road | | | | 10f. ZIP CODE
21811 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Retired | | 16b. KIND OF BUSINESS/INDUSTRY
Textile | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Macdonald | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Jeanne (Murray) | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Deanna Boal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9142 Old Ocean City Road; Berlin, MD 21811 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Frostburg Memorial Park | | DATE
02/18 | | 20c. LOCATION — City or Town, State
Frostburg, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James F. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Felty's Syndrome
DUE TO (OR AS A CONSEQUENCE OF):
Congestive Heart Failure | | | | | | | | Approximate Interval Between Onset and Death
days
years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jeffrey E. Herenton</i> | | 29c. LICENSE NUMBER
D36783 | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeffrey E. Herenton, MD, PRMC, SALISBURY, MD 21801 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John B. ...</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06793

ITEM: 23 PART I, PER DR. FILM G-726 8/30/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DEBORAH LYNN MILLER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 16 1995 | | | | 3. TIME OF DEATH
9:50 AM | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
217-74-9991 | | | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
33 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
DEC 8 1961 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | | | 9c. COUNTY OF DEATH
ALLEGANY | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
ALLEGANY | | | | 10c. CITY, TOWN OR LOCATION
CUMBERLAND | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
12 CHEROKEE DRIVE | | | | | | | | 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12+2
College (14 or 5+) | | | | | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
RADIOLOGY DEPT. MEMORIAL HOSPITAL | | | | 16b. KIND OF BUSINESS/INDUSTRY
RADIOLOGY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
RONALD D. HAWK | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
VALERIA JEAN WOLFE | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DR. ROBERT F. MILLER | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 CHEROKEE DRIVE CUMBERLAND MARYLAND 21502 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
REST LAWN CEMETERY FEB 19 1995 | | | | 20c. LOCATION — City or Town, State
LAVALE MARYLAND | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Dale L. Merritt</i> | | | | | | | | 22. NAME AND ADDRESS OF FACILITY
MERRITT-ADAMS FUNERAL HOME
404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Breast Cancer</i> | | | | | | | | | | | | | | | | | |
| b. <i>breast metastasis</i> | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>hypertension</i> | | | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Vik Poonai</i> | | | | | | | | 29c. LICENSE NUMBER
D 36766 | | | | 29d. DATE SIGNED (Month, Day, Year)
FEB 17 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. VIK POONAI 719 WILLIAMS STREET CUMBERLAND MARYLAND 21502 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Andrew Karsh</i> | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06794

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ORVILLE G. MICHAEL | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 13, 1995 | | 3. TIME OF DEATH
6:00 P M | |
| 4. SOCIAL SECURITY NUMBER
220-10-7269 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
October 9, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country)
West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cumberland | |
| 9c. COUNTY OF DEATH
Allegany | | | | 10a. STATE
West Virginia | | 10b. COUNTY
Mineral | |
| 10c. CITY, TOWN OR LOCATION
Wiley Ford | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
Rt. 1, Box 111 | |
| 10f. ZIP CODE
26767 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 6+) 10 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY
Self Employed | |
| 17. FATHER'S NAME (First, Middle, Last)
Taylor M. Michael | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara E. Kessel | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Goldie M. Michael | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1, Box 111 Wiley Ford, WV 26767 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maysville Cemetery February 16, 1995 | | 20c. LOCATION — City or Town, State
Maysville, West Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Brian R. Smith | | | | 22. NAME AND ADDRESS OF FACILITY
Rotruck-Smith Funeral Home
85 S. Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dissolution Thoracic aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval between Onset and Death 7 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert Orlino | | | | 29c. LICENSE NUMBER
034846 | | 29d. DATE SIGNED (Month, Day, Year)
February 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Robert Orlino 902 Seton Drive, Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed with the information required by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06795

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Frank Meadows | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 20, 1995 | | | | 3. TIME OF DEATH
9:15 a.m. | | | | | |
| 4. SOCIAL SECURITY NUMBER
218-09-8992 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 2, 1912 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
112 Red Toad Road | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
North East | | | | 9c. COUNTY OF DEATH
Cecil | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Havre de Grace | | | | 10e. STREET AND NUMBER
1413 Ontario Street | | | | | |
| 10f. ZIP CODE
21078 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Construction | | | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Houston E. Meadows | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie Florence Shifflett | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Janice Sadler | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1413 Ontario St., Havre de Grace, MD 21078 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Baker Cemetery 2/23 | | | | 20c. LOCATION — City or Town, State
Aberdeen, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced atherosclerotic Cardiovascular disease
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Diabetes mellitus
c. diabetic Gastropathy
d. | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Blind due to glaucoma | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Brian T. Yeo M.D. | | | | | | 29c. LICENSE NUMBER
D15152 | | 29d. DATE SIGNED (Month, Day, Year)
2/21/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Brian T. Yeo, M.D. 801 South Union Ave., Havre de Grace, MD 21078 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. HEALTH CARE PROVIDER'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06796

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELSIE Louise MOORE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 19, 1995 | | 3. TIME OF DEATH
0240 M | |
| 4. SOCIAL SECURITY NUMBER
578-01-7323 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 25, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
PRINCE FREDERICK, MD. | |
| 9c. COUNTY OF DEATH
CALVERT | | | | 10a. STATE
Maryland | | 10b. COUNTY
Calvert | |
| 10c. CITY, TOWN OR LOCATION
North Beach | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
4031 7th Street | |
| 10f. ZIP CODE
20714 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Cora Rackey | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles Kidwell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9404 Caldron Drive Clinton, Md 20735 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 1995 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End Stage Chronic Obstructive Pulmonary Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
033123 | | 29d. DATE SIGNED (Month, Day, Year)
2-19-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CECELIA VIRGINIA MASSEY | | | | 2. DATE OF DEATH
FEBRUARY 17, 1995 | | 3. TIME OF DEATH
3:27P | |
| 4. SOCIAL SECURITY NUMBER
216-22-3436 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAY 31, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
PHYSICIANS MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
LA PLATA | |
| 9c. COUNTY OF DEATH
CHARLES | | | | 10a. STATE
MARYLAND | | | |
| 10b. COUNTY
CHARLES | | | | 10c. CITY, TOWN OR LOCATION
POMONKEY | | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
#5805 BUMPY OAK ROAD | | | |
| 10f. ZIP CODE
20646 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
6TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
EXPLOSIVE WORKER | | 16b. KIND OF BUSINESS/INDUSTRY
GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last)
THOMAS CAMPBELL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BERTHA JOHNSON CAMPBELL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LA VERNE NELSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#69 GARNER AVENUE, WALDORF, MARYLAND 20602 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ST. CHARLES CEMETERY 2/22/95 | | 20c. LOCATION — City or Town, State
GLYMONT, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lydia C. Thornton Johnson</i>
LYDIA C. THORNTON JOHNSON MO0583 | | | | 22. NAME AND ADDRESS OF FACILITY
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Severe Ischaemic Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
b. Atherosclerotic Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Renal Failure on dialysis
DUE TO (OR AS A CONSEQUENCE OF):
d. Diabetic Nephropathy
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
— M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Mishra</i> | | | | 29c. LICENSE NUMBER
D-23021 | | 29d. DATE SIGNED (Month, Day, Year)
2/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SANJEEB K. MISHRA, MD. 7CPOST OFFICE ROAD, CENNA CENTER, WALDORF, MD. 20602 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06798

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
GLADYS HARING McCLENAHAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 17 1995 | | 3. TIME OF DEATH
0400 A.M. | |
| 4. SOCIAL SECURITY NUMBER
214-07-7774 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 2 1899 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Mallard Bay Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cambridge | | 9c. COUNTY OF DEATH
Dorchester | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Dorchester | | 10c. CITY, TOWN OR LOCATION
Cambridge | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
520 Glenburn Ave. | | | | 10f. ZIP CODE
21613 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
11 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
school teacher/sales clerk | | 16b. KIND OF BUSINESS/INDUSTRY
public schools
retail store | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Arthur Edwin Haring | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Catherine Wrightson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jane M. Henry | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1400 Hambrook Blvd., Cambridge MD 21613 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory 2/20 | | 20c. LOCATION — City or Town, State
Salisbury Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Benjamin L. Thomas Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Thomas Funeral Home
700 Locust St., Cambridge MD 21613 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate
Interval Between
Onset and Death
Years |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Organic Brain Syndrome</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>E. Tanman</i> | | | | 29c. LICENSE NUMBER
D14349 | | 29d. DATE SIGNED (Month, Day, Year)
2/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Eyup Tanman 15 Franklin St. Cambridge, MD 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

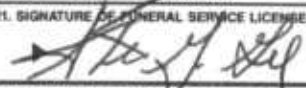
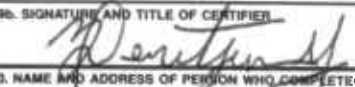

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06799

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Nancy Carroll Mann | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14 95 | | 3. TIME OF DEATH
HOURS MIN.
1401 | |
| 4. SOCIAL SECURITY NUMBER
222-20-7024 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS HOURS MIN.
56 | | 7. DATE OF BIRTH
(Month, Day, Year)
April 15, 1938 | |
| 8. BIRTHPLACE (State or Foreign Country)
PA. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Union Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
ELKTON | |
| 9c. COUNTY OF DEATH
Cecil | | | | 10a. STATE
MD. | | 10b. COUNTY
Cecil | |
| 10c. CITY, TOWN OR LOCATION
ELKTON | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
7 Old Locust Point Rd. | |
| 10f. ZIP CODE
21921 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
House Wife | | 16b. KIND OF BUSINESS/INDUSTRY
House Hold | | | |
| 17. FATHER'S NAME (First, Middle, Last)
David Coburn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Francis May Page | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Patricia Mann | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
328 Graymont Circle ELKTON, MD 21921 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Grace Lawn Cemetery 2-17-95 Wilmington, DE. | | 20c. LOCATION — City or Town, State
Wilmington, DE. | | 20d. OATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Gee Funeral Home
259 E. Main St. ELKTON, MD. 21921 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. ARDS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | c. Bilateral Viral Pneumonia
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Smoking / COPD Acute MI w/ CHF | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
130291 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert Denitzio 111 W. High St. Suite 204 ELKTON, MD 21921 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

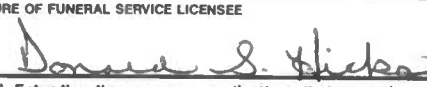


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06800

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Barbara J. MACKEY | | | | 2. DATE OF DEATH
MONTH February DAY 12 , YEAR 1995 | | | | 3. TIME OF DEATH
12:40 p. | |
| 4. SOCIAL SECURITY NUMBER
217-74-5114 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
43 YRS. | | IF UNDER 1 YEAR
MONTHS 43 DAYS 43 | | IF UNDER 24 HRS.
HOURS 43 MIN. 43 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Calvert Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rising Sun | | | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Elkton | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
735 Hilltop Road | | | | 10f. ZIP CODE
21921 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) n/a | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
n/a | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
Howard R. Mackey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ellen Bishop | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ellen B. Mackey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
735 Hilltop Road - Elkton, MD 21921 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Sharps Cemetery 2/15/95 | | | | 20c. LOCATION — City or Town, State
1995 Fair Hill, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Hicks Home for Funerals, P.A.
103 West Stockton Street
Elkton, MD 21921-5521 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Dehydration
DUE TO (OR AS A CONSEQUENCE OF):
c. Gastrointestinal hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
d. Severe mental retardation | | | | | | | | Approximate interval between Onset and Death
5 days
2 wks
2-3 wks
LIFE LONG | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BED RIDDEN 2° to CEREBRAL PALSEY | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D 94102 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William F. Renzulli, M.D. - 901 Warburton Road - Elkton, MD 21921 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06801

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William F. Nagel | | | | 2. DATE OF DEATH
MONTH 01 DAY 29 YEAR 95 | | 3. TIME OF DEATH
0753 M | |
| 4. SOCIAL SECURITY NUMBER
216-05-3229 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12/09/14 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital at Easton | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | |
| 9c. COUNTY OF DEATH
Talbot | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Federalsburg | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
4632 Preston Road | | | | 10f. ZIP CODE
21632 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) Seventh
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Salesman | | 16b. KIND OF BUSINESS/INDUSTRY
Feed and Egg | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Rudolph Nagel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Seiter | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William Leroy Nagel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
308 N. Main St., Federalsburg, MD 21632 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Concord Cemetery 2-1 | | 20c. LOCATION — City or Town, State
Federalsburg, MD | | 22. NAME AND ADDRESS OF FACILITY
Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 21632 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael F. Eskow | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Thomas Fauntleroy MD | | 29c. LICENSE NUMBER
D15315 | |
| 29d. DATE SIGNED (Month, Day, Year)
1/30/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Thomas Fauntleroy MD, 403 Marvel Court Easton Md. 21601 | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 03 '95 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06802

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Florence Nixon | | | | 2. DATE OF DEATH
MONTH February DAY 10 YEAR 1995 TIME 8:00 A M | | | | 3. TIME OF DEATH | | | | | |
| 4. SOCIAL SECURITY NUMBER
578-44-6598 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
12/6/11 | | 8. BIRTHPLACE (State or Foreign Country)
Sumter, S.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Laurel Regional Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | | 9c. COUNTY OF DEATH
Prince George's | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
P.G. | | 10c. CITY, TOWN OR LOCATION
Carmody Hills | | | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | | | | | |
| 10e. STREET AND NUMBER
6706 Blacklog St. | | | | | | 10f. ZIP CODE
20743 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Bill Wright | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Louisa Allen | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Harry F. Nixon | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as # 10 above | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 2/14/95 | | | | 20c. LOCATION — City or Town, State
Landover, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Harry H. Beatt | | | | | | 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF): MULTI - INFARCT DEMENTIA
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
N/A | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | | | 29c. LICENSE NUMBER
D24997 | | 29d. DATE SIGNED (Month, Day, Year)
2/10/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ZUIS A CASAS MD 8317 CHERRY LA. LAUREL MD 20707 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06803

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROBERT LOUIS NEWTON, SR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 11, 1995 | | 3. TIME OF DEATH
4:00P M | |
| 4. SOCIAL SECURITY NUMBER
577-76-8742 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
FEB. 28, 1958 | |
| 9a. FACILITY NAME (If not institution, give street and number)
1505 ARCADIA AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CAPITOL HEIGHTS | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
CAPITOL HEIGHTS | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1505 ARCADIA AVENUE | | | | 10f. ZIP CODE
20743 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TRUCK DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY
PVT. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
CLYDE S. NEWTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HELEN MONROE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CLYDE S. NEWTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1505 ARCADIA AVENUE CAPITOL HEIGHTS, MARYLAND 20743 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MARYLAND NATIONAL CEM. 2-17 | | 20c. LOCATION — City or Town, State
LAUREL, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Juanana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME 20785
7474 LANDOVER ROAD LANOVER, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCINOMA OF ESOPHAGO-GASTRIC JUNCTION
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____ | | | | | | | Approximate Interval Between Onset and Death
4 MONTHS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Harvey I. Katzen</i> | | | | 29c. LICENSE NUMBER
D20352 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HARVEY I. KATZEN MD 8926 Woodyard Rd. Clinton, MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Russell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06804

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARIE NAMYST | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 18 1995 | | | | 3. TIME OF DEATH
6:35 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER
579-52-4643 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
86 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
March 10 1908 | | 8. BIRTHPLACE (State or Foreign Country)
Germany | | | |
| 9a. FACILITY NAME (If not Institution, give street and number)
Fort Washington Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fort Washington | | | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Charles | | 10c. CITY, TOWN OR LOCATION
Waldorf | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
7375 Bensville Road | | | | 10f. ZIP CODE
20603 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Klara Thomas | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph A. Namyst Jr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7375 Bensville Road Waldorf, Maryland 20603 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Old Soldiers' Home Cem. 2-23-95 | | | | 20c. LOCATION — City or Town, State
Washington, DC | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 MO0173 | | | | 22. NAME AND ADDRESS OF FACILITY
J.H. Eberwein Mortuary
4433 White Pls. La. White Pls., MD 20695 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):
a.
b.
c.
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death
10 DAYS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
 | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | | | 29c. LICENSE NUMBER
D 35206 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 19, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
WILLIAM T. TANNER, MD 11701 LIVINGSTON RD STE. 101 FT. WASHINGTON, MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. MICHAEL'S COLLEGE

ST. MICHAEL'S COLLEGE

St. Michael's College

St. Michael's College

St. Michael's College

St. Michael's College

95 06805

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Beatrice M. Nixon | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 28, 1995 | | | | 3. TIME OF DEATH
0845 A^M | |
| 4. SOCIAL SECURITY NUMBER
219-42-3261 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
89 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
OCTOBER 14, 1905 | | 8. BIRTHPLACE (State or Foreign Country)
ENGLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | | | 9c. COUNTY OF DEATH
MONTGOMERY | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
GAITHERSBURG | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
8509 GOSHEN VIEW DRIVE | | | | 10f. ZIP CODE
20882 | | 10g. CITIZEN OF WHAT COUNTRY?
GREAT BRITAIN | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (13-16 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SALES PERSON M | | | 16b. KIND OF BUSINESS/INDUSTRY
DEPARTMENT STORE | | |
| 17. FATHER'S NAME (First, Middle, Last)
ERNEST - DOUGLAS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANNE - BARRASS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MARGARET ALLISON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8509 GOSHEN VIEW DRIVE GAITHERSBURG, MD. 20882 | | | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY 3/1/95 | | | 20c. LOCATION — City or Town, State
ALEXANDRIA, VIRGINIA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Muriel H. Barber</i> | | | | 22. NAME AND ADDRESS OF FACILITY
MURIEL H. BARBER FUNERAL HOME 20882
P.O. BOX 5038 LAYTONSVILLE, MARYLAND | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → BILATERAL PNEUMONIA | | | | | | | | | 11 DAYS |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST POSSIBLE ASPIRATION | | | | | | | | | 11 DAYS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
① Dehydration
② Coronary Artery Disease | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M.D.</i> | | | | 29c. LICENSE NUMBER
D35941 | | 29d. DATE SIGNED (Month, Day, Year)
2/28/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PURAN P. MATHUR #401 50 W Edmonston Dr. Rockville, Md 20852 | | | | | | | | | |
| 31. DATE (Month, Day, Year)
MAR 03 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 1975-1976 2. 1977-1978 3. 1979-1980 4. 1981-1982 5. 1983-1984 6. 1985-1986 7. 1987-1988 8. 1989-1990 9. 1991-1992 10. 1993-1994 11. 1995-1996 12. 1997-1998 13. 1999-2000 14. 2001-2002 15. 2003-2004 16. 2005-2006 17. 2007-2008 18. 2009-2010 19. 2011-2012 20. 2013-2014 21. 2015-2016 22. 2017-2018 23. 2019-2020 24. 2021-2022 25. 2023-2024 26. 2025-2026 27. 2027-2028 28. 2029-2030 29. 2031-2032 30. 2033-2034 31. 2035-2036 32. 2037-2038 33. 2039-2040 34. 2041-2042 35. 2043-2044 36. 2045-2046 37. 2047-2048 38. 2049-2050 39. 2051-2052 40. 2053-2054 41. 2055-2056 42. 2057-2058 43. 2059-2060 44. 2061-2062 45. 2063-2064 46. 2065-2066 47. 2067-2068 48. 2069-2070 49. 2071-2072 50. 2073-2074 51. 2075-2076 52. 2077-2078 53. 2079-2080 54. 2081-2082 55. 2083-2084 56. 2085-2086 57. 2087-2088 58. 2089-2090 59. 2091-2092 60. 2093-2094 61. 2095-2096 62. 2097-2098 63. 2099-2100 64. 2101-2102 65. 2103-2104 66. 2105-2106 67. 2107-2108 68. 2109-2110 69. 2111-2112 70. 2113-2114 71. 2115-2116 72. 2117-2118 73. 2119-2120 74. 2121-2122 75. 2123-2124 76. 2125-2126 77. 2127-2128 78. 2129-2130 79. 2131-2132 80. 2133-2134 81. 2135-2136 82. 2137-2138 83. 2139-2140 84. 2141-2142 85. 2143-2144 86. 2145-2146 87. 2147-2148 88. 2149-2150 89. 2151-2152 90. 2153-2154 91. 2155-2156 92. 2157-2158 93. 2159-2160 94. 2161-2162 95. 2163-2164 96. 2165-2166 97. 2167-2168 98. 2169-2170 99. 2171-2172 100. 2173-2174 101. 2175-2176 102. 2177-2178 103. 2179-2180 104. 2181-2182 105. 2183-2184 106. 2185-2186 107. 2187-2188 108. 2189-2190 109. 2191-2192 110. 2193-2194 111. 2195-2196 112. 2197-2198 113. 2199-2200 114. 2201-2202 115. 2203-2204 116. 2205-2206 117. 2207-2208 118. 2209-2210 119. 2211-2212 120. 2213-2214 121. 2215-2216 122. 2217-2218 123. 2219-2220 124. 2221-2222 125. 2223-2224 126. 2225-2226 127. 2227-2228 128. 2229-2230 129. 2231-2232 130. 2233-2234 131. 2235-2236 132. 2237-2238 133. 2239-2240 134. 2241-2242 135. 2243-2244 136. 2245-2246 137. 2247-2248 138. 2249-2250 139. 2251-2252 140. 2253-2254 141. 2255-2256 142. 2257-2258 143. 2259-2260 144. 2261-2262 145. 2263-2264 146. 2265-2266 147. 2267-2268 148. 2269-2270 149. 2271-2272 150. 2273-2274 151. 2275-2276 152. 2277-2278 153. 2279-2280 154. 2281-2282 155. 2283-2284 156. 2285-2286 157. 2287-2288 158. 2289-2290 159. 2291-2292 160. 2293-2294 161. 2295-2296 162. 2297-2298 163. 2299-2300 164. 2301-2302 165. 2303-2304 166. 2305-2306 167. 2307-2308 168. 2309-2310 169. 2311-2312 170. 2313-2314 171. 2315-2316 172. 2317-2318 173. 2319-2320 174. 2321-2322 175. 2323-2324 176. 2325-2326 177. 2327-2328 178. 2329-2330 179. 2331-2332 180. 2333-2334 181. 2335-2336 182. 2337-2338 183. 2339-2340 184. 2341-2342 185. 2343-2344 186. 2345-2346 187. 2347-2348 188. 2349-2350 189. 2351-2352 190. 2353-2354 191. 2355-2356 192. 2357-2358 193. 2359-2360 194. 2361-2362 195. 2363-2364 196. 2365-2366 197. 2367-2368 198. 2369-2370 199. 2371-2372 200. 2373-2374 201. 2375-2376 202. 2377-2378 203. 2379-2380 204. 2381-2382 205. 2383-2384 206. 2385-2386 207. 2387-2388 208. 2389-2390 209. 2391-2392 210. 2393-2394 211. 2395-2396 212. 2397-2398 213. 2399-2400 214. 2401-2402 215. 2403-2404 216. 2405-2406 217. 2407-2408 218. 2409-2410 219. 2411-2412 220. 2413-2414 221. 2415-2416 222. 2417-2418 223. 2419-2420 224. 2421-2422 225. 2423-2424 226. 2425-2426 227. 2427-2428 228. 2429-2430 229. 2431-2432 230. 2433-2434 231. 2435-2436 232. 2437-2438 233. 2439-2440 234. 2441-2442 235. 2443-2444 236. 2445-2446 237. 2447-2448 238. 2449-2450 239. 2451-2452 240. 2453-2454 241. 2455-2456 242. 2457-2458 243. 2459-2460 244. 2461-2462 245. 2463-2464 246. 2465-2466 247. 2467-2468 248. 2469-2470 249. 2471-2472 250. 2473-2474 251. 2475-2476 252. 2477-2478 253. 2479-2480 254. 2481-2482 255. 2483-2484 256. 2485-2486 257. 2487-2488 258. 2489-2490 259. 2491-2492 260. 2493-2494 261. 2495-2496 262. 2497-2498 263. 2499-2500 264. 2501-2502 265. 2503-2504 266. 2505-2506 267. 2507-2508 268. 2509-2510 269. 2511-2512 270. 2513-2514 271. 2515-2516 272. 2517-2518 273. 2519-2520 274. 2521-2522 275. 2523-2524 276. 2525-2526 277. 2527-2528 278. 2529-2530 279. 2531-2532 280. 2533-2534 281. 2535-2536 282. 2537-2538 283. 2539-2540 284. 2541-2542 285. 2543-2544 286. 2545-2546 287. 2547-2548 288. 2549-2550 289. 2551-2552 290. 2553-2554 291. 2555-2556 292. 2557-2558 293. 2559-2560 294. 2561-2562 295. 2563-2564 296. 2565-2566 297. 2567-2568 298. 2569-2570 299. 2571-2572 300. 2573-2574 301. 2575-2576 302. 2577-2578 303. 2579-2580 304. 2581-2582 305. 2583-2584 306. 2585-2586 307. 2587-2588 308. 2589-2590 309. 2591-2592 310. 2593-2594 311. 2595-2596 312. 2597-2598 313. 2599-2600 314. 2601-2602 315. 2603-2604 316. 2605-2606 317. 2607-2608 318. 2609-2610 319. 2611-2612 320. 2613-2614 321. 2615-2616 322. 2617-2618 323. 2619-2620 324. 2621-2622 325. 2623-2624 326. 2625-2626 327. 2627-2628 328. 2629-2630 329. 2631-2632 330. 2633-2634 331. 2635-2636 332. 2637-2638 333. 2639-2640 334. 2641-2642 335. 2643-2644 336. 2645-2646 337. 2647-2648 338. 2649-2650 339. 2651-2652 340. 2653-2654 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2787-2788 408. 2789-2790 409. 2791-2792 410. 2793-2794 411. 2795-2796 412. 2797-2798 413. 2799-2800 414. 2801-2802 415. 2803-2804 416. 2805-2806 417. 2807-2808 418. 2809-2810 419. 2811-2812 420. 2813-2814 421. 2815-2816 422. 2817-2818 423. 2819-2820 424. 2821-2822 425. 2823-2824 426. 2825-2826 427. 2827-2828 428. 2829-2830 429. 2831-2832 430. 2833-2834 431. 2835-2836 432. 2837-2838 433. 2839-2840 434. 2841-2842 435. 2843-2844 436. 2845-2846 437. 2847-2848 438. 2849-2850 439. 2851-2852 440. 2853-2854 441. 2855-2856 442. 2857-2858 443. 2859-2860 444. 2861-2862 445. 2863-2864 446. 2865-2866 447. 2867-2868 448. 2869-2870 449. 2871-2872 450. 2873-2874 451. 2875-2876 452. 2877-2878 453. 2879-2880 454. 2881-2882 455. 2883-2884 456. 2885-2886 457. 2887-2888 458. 2889-2890 459. 2891-2892 460. 2893-2894 461. 2895-2896 462. 2897-2898 463. 2899-2900 464. 2901-2902 465. 2903-2904 466. 2905-2906 467. 2907-2908 468. 2909-2910 469. 2911-2912 470. 2913-2914 471. 2915-2916 472. 2917-2918 473. 2919-2920 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3053-3054 541. 3055-3056 542. 3057-3058 543. 3059-3060 544. 3061-3062 545. 3063-3064 546. 3065-3066 547. 3067-3068 548. 3069-3070 549. 3071-3072 550. 3073-3074 551. 3075-3076 552. 3077-3078 553. 3079-3080 554. 3081-3082 555. 3083-3084 556. 3085-3086 557. 3087-3088 558. 3089-3090 559. 3091-3092 560. 3093-3094 561. 3095-3096 562. 3097-3098 563. 3099-3100 564. 3101-3102 565. 3103-3104 566. 3105-3106 567. 3107-3108 568. 3109-3110 569. 3111-3112 570. 3113-3114 571. 3115-3116 572. 3117-3118 573. 3119-3120 574. 3121-3122 575. 3123-3124 576. 3125-3126 577. 3127-3128 578. 3129-3130 579. 3131-3132 580. 3133-3134 581. 3135-3136 582. 3137-3138 583. 3139-3140 584. 3141-3142 585. 3143-3144 586. 3145-3146 587. 3147-3148 588. 3149-3150 589. 3151-3152 590. 3153-3154 591. 3155-3156 592. 3157-3158 593. 3159-3160 594. 3161-3162 595. 3163-3164 596. 3165-3166 597. 3167-3168 598. 3169-3170 599. 3171-3172 600. 3173-3174 601. 3175-3176 602. 3177-3178 603. 3179-3180 604. 3181-3182 605. 3183-3184 606. 3185-3186 607. 3187-3188 608. 3189-3190 609. 3191-3192 610. 3193-3194 611. 3195-3196 612. 3197-3198 613. 3199-3200 614. 3201-3202 615. 3203-3204 616. 3205-3206 617. 3207-3208 618. 3209-3210 619. 3211-3212 620. 3213-3214 621. 3215-3216 622. 3217-3218 623. 3219-3220 624. 3221-3222 625. 3223-3224 626. 3225-3226 627. 3227-3228 628. 3229-3230 629. 3231-3232 630. 3233-3234 631. 3235-3236 632. 3237-3238 633. 3239-3240 634. 3241-3242 635. 3243-3244 636. 3245-3246 637. 3247-3248 638. 3249-3250 639. 3251-3252 640. 3253-3254 641. 3255-3256 642. 3257-3258 643. 3259-3260 644. 3261-3262 645. 3263-3264 646. 3265-3266 647. 3267-3268 648. 3269-3270 649. 3271-3272 650. 3273-3274 651. 3275-3276 652. 3277-3278 653. 3279-3280 654. 3281-3282 655. 3283-3284 656. 3285-3286 657. 3287-3288 658. 3289-3290 659. 3291-3292 660. 3293-3294 661. 3295-3296 662. 3297-3298 663. 3299-3300 664. 3301-3302 665. 3303-3304 666. 3305-3306 667. 3307-3308 668. 3309-3310 669. 3311-3312 670. 3313-3314 671. 3315-3316 672. 3317-3318 673. 3319-3320 674. 3321-3322 675. 3323-3324 676. 3325-3326 677. 3327-3328 678. 3329-3330 679. 3331-3332 680. 3333-3334 681. 3335-3336 682. 3337-3338 683. 3339-3340 684. 3341-3342 685. 3343-3344 686. 3345-3346 687. 3347-3348 688. 3349-3350 689. 3351-3352 690. 3353-3354 691. 3355-3356 692. 3357-3358 693. 3359-3360 694. 3361-3362 695. 3363-3364 696. 3365-3366 697. 3367-3368 698. 3369-3370 699. 3371-3372 700. 3373-3374 701. 3375-3376 702. 3377-3378 703. 3379-3380 704. 3381-3382 705. 3383-3384 706. 3385-3386 707. 3387-3388 708. 3389-3390 709. 3391-3392 710. 3393-3394 711. 3395-3396 712. 3397-3398 713. 3399-3400 714. 3401-3402 715. 3403-3404 716. 3405-3406 717. 3407-3408 718. 3409-3410 719. 3411-3412 720. 3413-3414 721. 3415-3416 722. 3417-3418 723. 3419-3420 724. 3421-3422 725. 3423-3424 726. 3425-3426 727. 3427-3428 728. 3429-3430 729. 3431-3432 730. 3433-3434 731. 3435-3436 732. 3437-3438 733. 3439-3440 734. 3441-3442 735. 3443-3444 736. 3445-3446 737. 3447-3448 738. 3449-3450 739. 3451-3452 740. 3453-3454 741. 3455-3456 742. 3457-3458 743. 3459-3460 744. 3461-3462 745. 3463-3464 746. 3465-3466 747. 3467-3468 748. 3469-3470 749. 3471-3472 750. 3473-3474 751. 3475-3476 752. 3477-3478 753. 3479-3480 754. 3481-3482 755. 3483-3484 756. 3485-3486 757. 3487-3488 758. 3489-3490 759. 3491-3492 760. 3493-3494 761. 3495-3496 762. 3497-3498 763. 3499-3500 764. 3501-3502 765. 3503-3504 766. 3505-3506 767. 3507-3508 768. 3509-3510 769. 3511-3512 770. 3513-3514 771. 3515-3516 772. 3517-3518 773. 3519-3520 774. 3521-3522 775. 3523-3524 776. 3525-3526 777. 3527-3528 778. 3529-3530 779. 3531-3532 780. 3533-3534 781. 3535-3536 782. 3537-3538 783. 3539-3540 784. 3541-3542 785. 3543-3544 786. 3545-3546 787. 3547-3548 788. 3549-3550 789. 3551-3552 790. 3553-3554 791. 3555-3556 792. 3557-3558 793. 3559-3560 794. 3561-3562 795. 3563-3564 796. 3565-3566 797. 3567-3568 798. 3569-3570 799. 3571-3572 800. 3573-3574 801. 3575-3576 802. 3577-3578 803. 3579-3580 804. 3581-3582 805. 3583-3584 806. 3585-3586 807. 3587-3588 808. 3589-3590 809. 3591-3592 810. 3593-3594 811. 3595-3596 812. 3597-3598 813. 3599-3600 814. 3601-3602 815. 3603-3604 816. 3605-3606 817. 3607-3608 818. 3609-3610 819. 3611-3612 820. 3613-3614 821. 3615-3616 822. 3617-3618 823. 3619-3620 824. 3621-3622 825. 3623-3624 826. 3625-3626 827. 3627-3628 828. 3629-3630 829. 3631-3632 830. 3633-3634 831. 3635-3636

95 06806

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Russell - Reid</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>OFF HAUS FEBRUARY 14, 1995</i> | | | | 3. TIME OF DEATH
<i>0535 M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>243-56-3360</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>53</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>July 13, 1941</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Massachusetts</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>PENINSULA REGIONAL MEDICAL CENTER</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>SALISBURY</i> | | | | 9c. COUNTY OF DEATH
<i>WICOMICO</i> | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
<i>Virginia</i> | | 10b. COUNTY
<i>Accomack</i> | | 10c. CITY, TOWN OR LOCATION
<i>Chincoteague</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>8089 Bowden Lane</i> | | | | 10f. ZIP CODE
<i>23336</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
<i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>5</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Electronic Tech</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Government Contractor</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Russell E. Offhaus</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Rosetta Regina Reid</i> | | | | | |
| 19. INFORMANT'S NAME (Print)
<i>Cherly R. Offhaus</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>Chincoteague, Virginia 23336</i> | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place)
<i>Forest Lawn Cemetery</i> | | | | DATE | | 20c. LOCATION — City or Town, State
<i>Ashville, N. C.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>TA Constante Salva Gordon</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Salva Funeral Home Chincoteague, Virginia 23336</i> | | | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. <i>Electro Medial Desync</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Card Condy Shock</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>Acid Myocardial Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. <i>Alcohol Cardiac Arrest</i> | | | | | | | | Approximate Interval Between Onset and Death
<i>Min</i>
<i>4</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cerebral Vascular Disease</i>
<i>Hypertension</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John S. Green MD</i> | | | | 29c. LICENSE NUMBER
<i>02020</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2/14/95</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>John G. Green MD</i> <i>Ronald C. Hay</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 15 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John D. Walker</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 06807

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Roberts Puckett | | | | 2. DATE OF DEATH
MONTH 2 DAY 22 YEAR 95 | | 3. TIME OF DEATH
8:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER
215-58-5001 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
41 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11/10/53 | |
| 9a. FACILITY NAME (If not institution, give street and number)
McCready Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Crisfield | | 9c. COUNTY OF DEATH
Somerset | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Somerset | | 10c. CITY, TOWN OR LOCATION
Rehobeth | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
31310 Rehobeth RD | | | | 10f. ZIP CODE
21871 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Poultry Grower | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | |
| 17. FATHER'S NAME (First, Middle, Last)
Howard Olden Puckett, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie Lee Anthony | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jane Hastings | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9840 Hastings Lane Ocean City, MD 21842 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Riverside Cemetery | | DATE
2/25/95 | | 20c. LOCATION — City or Town, State
Libertytown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>H. B. Burtage</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
Inst. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Over/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James A. Sterling, MD</i> | | | | 29c. LICENSE NUMBER
D10814 | | 29d. DATE SIGNED (Month, Day, Year)
2/22/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
James A. Sterling, MD - 320 W. Main St. - Crisfield, MD 21817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John D. Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COLLIER PAPER

12-20-1911

James A. Smith, Jr. - 12-20-1911

95 06808

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Clarence Gray Poe | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 15, 1995 | | 3. TIME OF DEATH
1:45p. M | |
| 4. SOCIAL SECURITY NUMBER
214-20-1322 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Oct. 30, 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | 9c. COUNTY OF DEATH
St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Piney Point | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
P.O. Box 293 | | | | 10f. ZIP CODE
20674 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
7th grade | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Waterman | | 16b. KIND OF BUSINESS/INDUSTRY
Seafood | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George Poe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Ellen Potter | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Francis A. Pasik | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 293, Piney Point, Maryland 20674 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 2/20/95 | | 20c. LOCATION — City or Town, State
Leonardtwn, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i> | | | | | | | |
| b. <i>Coronary Artery Disease</i> | | | | | | | |
| c. <i>Hypertension</i> | | | | | | | |
| d. <i></i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Myocardial Infarction</i>
<i>Senile Degeneration</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Gil De Los Reyes</i> | | | | 29c. LICENSE NUMBER
D17677 | | 29d. DATE SIGNED (Month, Day, Year)
15 Feb 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gil De Los Reyes, M.D. Hollywood, Maryland 20636 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06809

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NELSON JOSEPH PEARSALL, JR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 12 1995 | | 3. TIME OF DEATH
HOURS MINUTES AM/PM
8:45 A M | |
| 4. SOCIAL SECURITY NUMBER
215-14-5170 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
February 26, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | |
| 9c. COUNTY OF DEATH
Talbot | | | | 10a. STATE
Maryland | | 10b. COUNTY
Caroline | |
| 10c. CITY, TOWN OR LOCATION
Denton | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
24078 Willow Pond Road | |
| 10f. ZIP CODE
21629 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1942-1943 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Supervisor | | | | 16b. KIND OF BUSINESS/INDUSTRY
Parole and Probation | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Nelson Joseph Pearsall, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catharine Mueller Jacobson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Loisann Pearsall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24078 Willow Pond Road, Denton, Maryland 21629 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | | |
| 20c. LOCATION — City or Town, State
Denton, Maryland | | | | 20d. DATE
2/16 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Rudolph P. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home
Drawer B
Denton, Maryland | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
12 days
12 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
lung carcinoma, COPD, Redden pneumonia, coronary artery disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
2/12/95 | | | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>D. Gregg Oliver</i> | | | | 29c. LICENSE NUMBER
059749 | | | |
| 29d. DATE SIGNED (Month, Day, Year)
2/12/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
D. Gregg Oliver, M.D., 503 Dutchmen's Lane, Easton, Maryland 21601 | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 '95 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06810

Amended Items #4 & #7 2/20/95 WCHD jrd

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROSETTA BLUE PURNELL | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 12, 1995 | | 3. TIME OF DEATH
0320 M | |
| 4. SOCIAL SECURITY NUMBER
224-22-9856 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
10 25 25 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD. | | 10b. COUNTY
WORCESTER | | 10c. CITY, TOWN OR LOCATION
BERLIN | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8809 LEWIS ROAD | | | | 10f. ZIP CODE
21811 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5th College (1-4 or 5+) | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY
HOUSEKEEPER | | | |
| 17. FATHER'S NAME (First, Middle, Last)
PETER D. BLUE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANNIE THOMPSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBERT PURNELL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ADDRESS SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)
EVERGREEN | | DATE
2-18 | | 20c. LOCATION — City or Town, State
BERLIN, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Patricia L. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY
JOLLEY MEMORIAL CHAPEL: 1213 JERSEY ROAD,
SALISBURY, MD. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <i>Valvular Conductionopathy</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Mitral Regurgitation</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
months
years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jeffrey R. Henton</i> | | | | 29c. LICENSE NUMBER
D36783 | | 29d. DATE SIGNED (Month, Day, Year)
2/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeffrey R. Henton, MD PRINC Salisbury, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Jahia Shweider-Randall</i> 21801 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06811

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
IRENE IVY PALMER | | | 2. DATE OF DEATH
MONTH 2 DAY 19 YEAR 95 | | 3. TIME OF DEATH
9:05A | |
| 4. SOCIAL SECURITY NUMBER
218 096609 | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 7, 1918 | |
| 8. BIRTHPLACE (State or Foreign Country)
VIRGINIA | | | 9. COUNTRY OF DEATH
CARROLL | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
CARROLL COUNTY GENERAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH
WESTMINSTER | | | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE
MARYLAND | 10b. COUNTY
CARROLL | 10c. CITY, TOWN OR LOCATION
WESTMINSTER | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
1013 SHARON LANE | | 10f. ZIP CODE
21157 | | 10g. CITIZEN OF WHAT COUNTRY?
USA. | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
HOME MAKING | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JOSEPH ISENBURG | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FANNIE MAXWELL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
GEORGE PALMER, JR. | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1013 SHARON LANE, WESTMINSTER, MD. 21157 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
EVERGREEN MEM. GARDENS 2/21 | | 20c. LOCATION — City or Town, State
FINKSBURG, MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Consecutive heart failure, ASCVD
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Complete heart block
c. C-O-P-D
d. I-D-D-M | | | | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY
M | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D39502 | 29d. DATE SIGNED (Month, Day, Year)
2/19/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SYBIO - S. HOSKIN MD. Carol Co - Gen - Hosp. | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06812

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
RALPH BEVERE PRICE | | | | 2. DATE OF DEATH
MONTH 2 / DAY 17 / YEAR 95 | | 3. TIME OF DEATH
16:00 PM | |
| 4. SOCIAL SECURITY NUMBER
078-28-8595 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 27, 1912 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Carroll County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Westminster | | 9c. COUNTY OF DEATH
Carroll | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Carroll | | 10c. CITY, TOWN OR LOCATION
Westminster | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
205 St. Mark Way, Apt. #117 | | | | 10f. ZIP CODE
21158 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
economics professor | | 16b. KIND OF BUSINESS/INDUSTRY
college | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Ralph B. Price, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kathryn Gallagher | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Pamela G. Price | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacob AALS GT.26 00368 Oslo, Norway | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. 2/18 | | 20c. LOCATION — City or Town, State
Hampstead, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Catharine O. Hartzler</i> | | | | 22. NAME AND ADDRESS OF FACILITY
D.D. Hartzler & Sons
New Windsor, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Pulmonary Edema
DUE TO (OR AS A CONSEQUENCE OF):
b. ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Sepsis, Bilateral pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Cardiomyopathy; congestive
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Heart Failure Ventricular tachycardia
S/P AICD placement | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Heart Failure Ventricular tachycardia
S/P AICD placement | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Paul J. [Signature]</i> | | | | 29c. LICENSE NUMBER
D38915 | | 29d. DATE SIGNED (Month, Day, Year)
2/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FREIST 542 WASH RD Westminster MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia [Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Sophia Merle Parry | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 15, 1995 | | 3. TIME OF DEATH
4:50 a.m. | |
| 4. SOCIAL SECURITY NUMBER
092-01-1226
015-14-1647 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
July 10, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Calvert Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rising Sun | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Rising Sun | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1881 Telegraph Road | | | | 10f. ZIP CODE
21911 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
----- Two Years | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government
Washington, D.C. | |
| 17. FATHER'S NAME (First, Middle, Last)
John Henry Keller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catherine Shipley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joyce Fowble | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 1, Osborne Road, Boring, Maryland 21021 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Memorial Gardens 2/20/95 | | 20c. LOCATION — City or Town, State
Finksburg, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lee A. Patterson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee A. Patterson & Son Funeral Home
Perryville, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Acute Congestive Heart Failure</i> | | | | | Approximate Interval Between Onset and Death
IMMEDI |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Shunt Arteriosclerosis, Coronary</i> | | | | | 10 YRS |
| | | c. <i>Artery disease, Cerebral Artery disease</i> | | | | | 10 YRS |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Malcolm Dudley Phillips M.D.</i> | | | | 29c. LICENSE NUMBER
D09482 | | 29d. DATE SIGNED (Month, Day, Year)
2/16/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Malcolm Dudley Phillips, M.D., P.O. Box 300, Darlington, Maryland 21034 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Juba Davidson-Randall</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95-0899-047
DWG

95 06814

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NORMAN LEE OUILLEN | | | | 2. DATE OF DEATH
MONTH FEB. DAY 18 YEAR 95 | | 3. TIME OF DEATH
10:29P M | |
| 4. SOCIAL SECURITY NUMBER
217-76-6229 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/5/60 | |
| 9a. FACILITY NAME (If not institution, give street and number)
ATLANTIC GENERAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | | 9c. COUNTY OF DEATH
WORCESTER | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Berlin | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11143 Grays Corner RD | | | | 10f. ZIP CODE
21811 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Truck Driver/Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY
Trucking | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Raymond Joseph Quillen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Frances Hudson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Patricia Wilkerson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RT 2 Box 350A Millsboro, DE 19966 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Cemetery 2/22/95 | | 20c. LOCATION — City or Town, State
Berlin, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2/18/95 | | 28b. TIME OF INJURY
2149 M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED
VEHICLE STRUCK TREE | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
ROADWAY | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
ROUTE 113 SOUTH OF ROUTE 589 | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)
BERLIN MD | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donald G. Wright MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06815

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rachelle Marie Reibsome | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 9, 1995 | | 3. TIME OF DEATH
6:45 A M | |
| 4. SOCIAL SECURITY NUMBER
167-44-6031 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 8, 1952 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | 9a. FACILITY NAME (If not institution, give street and number)
8 Magee Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Leonardtwn | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Rt. 3 Box 8 Magee Drive | | 10f. ZIP CODE
20650 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
9h Grade | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Lab Technician | | 15b. KIND OF BUSINESS/INDUSTRY
Hospital | |
| 17. FATHER'S NAME (First, Middle, Last)
Clarence Clinton Shultz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rachel May Barlet | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Warren William Reibsome | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 3 Box 8 Magee Dr., Leonardtown, MD 20650 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial Gardens 2/13/95 Leonardtown, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael K. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Adenocarcinoma of lung</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David Allen</i>
29c. LICENSE NUMBER
D25230
29d. DATE SIGNED (Month, Day, Year)
2/10/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David Allen, M.D. Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06816

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Luella M. Reed | | | | 2. DATE OF DEATH
MONTH 2 DAY 13 YEAR 95 | | 3. TIME OF DEATH
4:30 pm | |
| 4. SOCIAL SECURITY NUMBER
213-03-9748 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09/29/16 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
William Hill Manor | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Easton | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
501 Dutchman's Lane-Wm. Hill Manor | | | | 10f. ZIP CODE
21601 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Albert Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Katherine Riley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles L. McNeal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22590 Tanyard Rd., Preston, MD 21655 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hill Crest Cemetery 2-16 | | DATE
2-16 | | 20c. LOCATION — City or Town, State
Federalsburg, MD | |
| 21. SIGNATURE OF FUNERAL LICENSEE
Michael F. Eckert | | 22. NAME AND ADDRESS OF FACILITY
Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 21632 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Parkinson Dz
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
75 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
R. A. Burgoyne MD | | | | 29c. LICENSE NUMBER
D92811- | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R. A. Burgoyne 607 Dutchmans Lane Easton MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
2/14/95 FEB 15 '95 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06817

ITEMS: 6.7.10c,10e,10f, PER INFORMANT FILM G-722 4/5/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
WALTER THOMAS ROSS | | | | 2. DATE OF DEATH
MONTH February DAY 12 YEAR 1995 | | 3. TIME OF DEATH
1:26 a m | |
| 4. SOCIAL SECURITY NUMBER
220-48-1029 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
49 48 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
July 10, 1945 | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Parsonsburg WILLARDS | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
#9 Moon Glow Court 35106 EARLY GLOW COURT | | | | 10f. ZIP CODE
21849-21874 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Army | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY
Delmarva Power & Light Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Melvin V. Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mildred Peregoy | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Melvin V. Ross Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11645 Manklin Creek Rd., Berlin, MD 21811 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory | | DATE
2/13 | | 20c. LOCATION — City or Town, State
Salisbury, MD 21801 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D03599 | | 29d. DATE SIGNED (Month, Day, Year)
2/12/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06818

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Walfred William Rose | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 14 1995 | | 3. TIME OF DEATH
4:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
161 16 3284 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 19, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number)
13403 Youngwood Turn | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bowie | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Bowie | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13403 Youngwood Turn | | | | 10f. ZIP CODE
20715 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+
College (1-4 or 5+) 5+ | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
U.S. Aide Official | | 18b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Eric Issac Rose | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kristina Palso | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Bertha Rose | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13403 Youngwood Turn Bowie Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory | | DATE | | 20c. LOCATION — City or Town, State
Alexandria Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert E. Evans Pres.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Congestive Heart Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
<i>5 years</i>
<i>10 years</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Cardiomyopathy</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donald L. [Signature]</i> | | | | 29c. LICENSE NUMBER
D 00360 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LEONARD P. HOPEL, M.D. 3231 SUPERIOR LA. BOWIE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #9a, 2/14/95, CYW, P.G. COUNTY

95 06819

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY LILLIAN RICHARDSON | | | | 2. DATE OF DEATH
FEB. 10 1995 | | 3. TIME OF DEATH
8:45 P M | |
| 4. SOCIAL SECURITY NUMBER
577-92-9896 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/14/22 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MALCOLM GROVE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Camp Springs | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
14510 Church St. | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter B. Tippet | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude A. Coombs | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William Richardson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14510 Church St., Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 2/14/95 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Multiple Injuries</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2-10-95 | | 28b. TIME OF INJURY
7:30 PM | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Roadway | | 28e. DESCRIBE HOW INJURY OCCURRED
Passenger — auto collision | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Old Alexandria Ferry Rd | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 11, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0739-001

blh

Amended #9c, 2/15/95, N. L. S., Allegany Co.


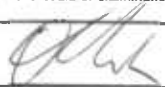

95 06820

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Glenn O. Ryan | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 11 1995 | | 3. TIME OF DEATH
0631 M | |
| 4. SOCIAL SECURITY NUMBER
220-16-5598 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 19, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cumberland | | 9c. COUNTY OF DEATH
Allegany | |
| 10a. STATE
Maryland | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Frostburg | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
10112 Crystal Lane, N.W. | | | | 10f. ZIP CODE
21532 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W.W. 2 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Concrete Worker | | 16b. KIND OF BUSINESS/INDUSTRY
Building Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Ryan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ada May Lancaster | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Michael Ryan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10114 Crystal Lane, N.W., Frostburg, Md. 21532 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cem. 2/15 Flintstone, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
57 Frost Ave.
Durst Funeral Home, Frostburg, Md. 21532 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Thromboembolism
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
01-16-95 | | 28b. TIME OF INJURY
unknown M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Roadway | | 28d. DESCRIBE HOW INJURY OCCURRED
Driver - auto coll. 31b | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
unknown | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
Feb 12 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE STATE OF NEW YORK

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REPORT

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Thelma Cassell Robertson | | | | 2. DATE OF DEATH
MONTH FEB DAY 12 YEAR 1995 | | 3. TIME OF DEATH
11:00 A M | |
| 4. SOCIAL SECURITY NUMBER
578-44-5455 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
AUG 12, 1934 | |
| 8. BIRTHPLACE (State or Foreign Country)
VIRGINIA | | | | 9a. FACILITY NAME (If not institution, give street and number)
5700 EAST PL. | | 9b. CITY, TOWN OR LOCATION OF DEATH
FORESTVILLE MARYLAND | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION
FORESTVILLE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5700 EAST PL | |
| 10f. ZIP CODE
20747 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CURRENCY EXAMINER | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last)
PERCY BROWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
NANNIE WITCHER JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JOHN ROBERTSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5700 EAST PL FORESTVILLE MARYLAND 20747 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
CEDAR HILL | | 20c. LOCATION — City or Town, State
2-1695 SUITLAND MARYLAND | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Alex S. Pope</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE FORESTVILLE MD 20747 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
e. Non-Small Cell Carcinoma of Lung
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval between Onset and Death
7 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Norman Lieberman MD</i> | | 29c. LICENSE NUMBER
D06682 md | | 29d. DATE SIGNED (Month, Day, Year)
02/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. NORMAN LIEBERMAN, M.D. 5100 AUTH WAY, SUITLAND, MARYLAND | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anna Lucille Ruppenthal | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 17 1995 | | 3. TIME OF DEATH
0535 M | |
| 4. SOCIAL SECURITY NUMBER
231-547745 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
54 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 24, 1940 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Washington County Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hagerstown | | 9c. COUNTY OF DEATH
WASHINGTON | | | |
| 10a. STATE
MD | | 10b. COUNTY
Washington | | 10c. CITY, TOWN OR LOCATION
Boonsboro | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
141 S. Main St. | | | | 10f. ZIP CODE
21713 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Russell Steiner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Dorcas Steiner DORA STEINER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James R. Ruppenthal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
113 Fairview Dr. Hancock, MD 21750 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greenway Cemetery 2/20/95 | | 20c. LOCATION — City or Town, State
Berkeley Springs, WV | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Richard S. Schure</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Grove Funeral Home
P.O. Box 368 Hancock, MD 21750 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Severe chronic obstructive Pulmonary disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
<i>h h m</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Ant. Myocardial Infarction 2 days before death</i>
<i>Cerebral Heart Failure Hypertension</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Sudden 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John M. D</i> | | 29c. LICENSE NUMBER
D18019 | | 29d. DATE SIGNED (Month, Day, Year)
2-18-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
VASANT DATTA, MD 334 MILL ST HAGERSTOWN MD 21740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John M. D</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MELBA ERA REED | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 13 1995 | | 3. TIME OF DEATH
5:27 P M | |
| 4. SOCIAL SECURITY NUMBER
218-03-3735 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV. 2, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
106 MAPLETON STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
HURLOCK | | 9c. COUNTY OF DEATH
DORCHESTER | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
DORCHESTER | | 10c. CITY, TOWN OR LOCATION
HURLOCK | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
106 MAPLETON STREET | | | | 10f. ZIP CODE
21643 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
QUALITY CONTROL INSPECTOR | | 16b. KIND OF BUSINESS/INDUSTRY
MANUFACTURING | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES G. ERA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARGARET WHEATLEY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
YVONNE R. PHILLIPS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4410 DRAWBRIDGE ROAD, CAMBRIDGE MD 21613 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
UNITY WASHINGTON CEMETERY 2/16 | | 20c. LOCATION — City or Town, State
HURLOCK, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leonard Beller</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ZELLER FUNERAL HOME, 106 MAIN STREET,
P. O. BOX 207, EAST NEW MARKET, MD 21631 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac myopathy</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Congestive Heart Failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Adult Distal Myelitis</i>
<i>Recent VITM Syndrome</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 26d. DESCRIBE NOW INJURY OCCURRED | | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Michael Madden</i> | | | | 29c. LICENSE NUMBER
<i>Dab388</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>2-15-95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Michael Madden MD Hurlock md 21643</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Drucker-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
REC'D

1914

1914

RECEIVED
REC'D

95-0878-033

blh

95 06824

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Michael Donald Reed</u> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<u>Feb 18 1995</u> | | 3. TIME OF DEATH
M
<u>0126</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>212 72 3111</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>29</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>November 22 1965</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Virginia</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>Prince Georges General Hospital</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Cheverly</u> | |
| 9c. COUNTY OF DEATH
<u>Prince Georges</u> | | | | 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Prince Georges</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Upper Marlboro</u> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>12904 Lakeston Court</u> | |
| 10f. ZIP CODE
<u>20772</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <u>white</u> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>self employed Roofer</u> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>self employed Roofer</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<u>construction</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Donald Nelson Reed</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Mary Virginia Goettel</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Mary V. Suthard</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>179 Deer Dr. Lusby Maryland 20657</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Metropolitan Funeral Service</u> <u>February 21, 1995</u> | | | |
| 20c. LOCATION — City or Town, State
<u>Alexandria Virginia</u> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>B. Rausch</u> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<u>Rausch Funeral Home</u>
<u>4405 Broomes Is. Rd. Port Republic Maryland 20676</u> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Gunsht wound of Abdomen</u>
Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
<u>2/18/95</u> | | | |
| 28b. TIME OF INJURY
<u>0030</u> M | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED
<u>Subject shot</u> | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<u>STREET</u> | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<u>1500 Blk Ritchie Highway RD</u> | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Carol Tolens</u> | | | | 29c. LICENSE NUMBER
<u>O.C.M.E.</u> | | | |
| 29d. DATE SIGNED (Month, Day, Year)
<u>Feb 18 1995</u> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>J. APEN WATKINS, MD</u> <u>111 Penn Street, Baltimore, Maryland 21201</u> | | | |
| 31. DATE FILED (Month, Day, Year)
<u>FEB 22 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0582-037
B.K.S

95 06825

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HANNAH Y. STOLZFUS | | | | 2. DATE OF DEATH
FEB. 2 1995 | | 3. TIME OF DEATH
1400 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER
N/A | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov 11, 1966 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
70 ANDERSON LANE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
MECHANICSVILLE | | | 9c. COUNTY OF DEATH
ST. MARY'S | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Mechanicsville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
70 Anderson Lane | | | | 10f. ZIP CODE
20659 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th Grade College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Amos S. Stoltzfus | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rebecca F. Yoder | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jacob H. Stoltzfus | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
70 Anderson Lane, Mechanicsville, Maryland 20659 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodburn Hill Cemetery 2/6/95 | | 20c. LOCATION — City or Town, State
Mechanicsville, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael J. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Shotgun wound to Back and
DUE TO (OR AS A CONSEQUENCE OF):
b. Blunt Force Injuries to Head
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2-2-95 | | 28b. TIME OF INJURY
UNK M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Subject shot and | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
HOME | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
70 ANDERSON LANE | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jason Locke MD</i> | | | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 3, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JASON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 1995 | | | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0543-037

DWG

95 06826

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
AMY LYNN SCOTT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
JAN. 31 95 | | 3. TIME OF DEATH
9:30A M | |
| 4. SOCIAL SECURITY NUMBER
218-04-4989 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
16 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Mar 22, 1978 | |
| 9a. FACILITY NAME (If not institution, give street and number)
ROUTE #5 NORTH OF COOKSEY SWAMP RD. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHARLOTTE HALL | | 9c. COUNTY OF DEATH
ST. MARY'S | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Charlotte Hall | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Rt. 2 Box 236 | | | | 10f. ZIP CODE
20622 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
10th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
High School | |
| 17. FATHER'S NAME (First, Middle, Last)
Randy Lee Scott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Loretta Jean Windsor | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Randy Lee Scott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 236, Charlotte Hall, MD 20622 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Trinity Memorial Gardens 2/3/95 | | 20c. LOCATION — City or Town, State
Waldorf, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEAD AND NECK INJURIES
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROAD WAY | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Other | | 28a. DATE OF INJURY (Month, Day, Year)
1/31/95 | | 28b. TIME OF INJURY
700 M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
STREET | | | | 28e. DESCRIBE NOW INJURY OCCURRED
MOTOR VEHICLE ACCIDENT | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
RTE #5 OAKS COCKSEY SWAMP RD. MACHENISVILLE, MD. | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donald A. Wright MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 01/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
for Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 02 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06827

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Harry James ST. AUBIN | | | | 2. DATE OF DEATH
MONTH FEB DAY 4 YEAR 1995 | | 3. TIME OF DEATH
9:09 A M | |
| 4. SOCIAL SECURITY NUMBER
378-30-4701 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
8-18-1932 | |
| 8. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Greensboro | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
25393 Depue Landing Way | | | | 10f. ZIP CODE
21639 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1949-1952 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
US Navy | |
| 17. FATHER'S NAME (First, Middle, Last)
Mose Joseph St. Aubin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eva Josephine Young | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marguerite E. St. Aubin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25393 Depue Landing Way, Greensboro, Md. 21639 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Eastern Shore Crematorium | | DATE
2/5 | | 20c. LOCATION — City or Town, State
Georgetown, Del. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph P. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, PA
Drawer B, 12 S. 2nd St. Denton, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 0 min. |
| b. Atherosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | years |
| c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
H41441 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gino Alberto DO Memorial Hospital Easton, MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 08 '95 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06828

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EDWARD LEE SCOTT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 5, 1995 | | 3. TIME OF DEATH
2:35P | |
| 4. SOCIAL SECURITY NUMBER
218-16-6644 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
October 26, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not Institution, give street and number)
Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | |
| 9c. COUNTY OF DEATH
Talbot | | | | 10a. STATE
Maryland | | 10b. COUNTY
Caroline | |
| 10c. CITY, TOWN OR LOCATION
Denton | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
26671 Burrsville Road | |
| 10f. ZIP CODE
21629 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 HS grad.
College (1-4 or 5+) Farmer | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Farming | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | |
| 17. FATHER'S NAME (First, Middle, Last)
Arthur William Scott, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara Dell Cohee | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Margaret I. Scott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26671 Burrsville Road, Denton, Maryland 21629 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | 20c. LOCATION — City or Town, State
2/8 Denton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph P. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A.
Drawer B, Denton, Maryland 21629 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Lymphoma
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
2 weeks | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Lymphoma | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David H. Smith</i> | | | | 29c. LICENSE NUMBER
D3987 | | 29d. DATE SIGNED (Month, Day, Year)
2/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David H. Smith, M.D., 509 Idlewild Avenue, Easton, Maryland 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 08 '95 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06829

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
RUTH HOWARD STEENKEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 11, 1995 | | 3. TIME OF DEATH
3:30 A M | |
| 4. SOCIAL SECURITY NUMBER
216-18-2585 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
05/30/14 | |
| 9a. FACILITY NAME (If not institution, give street and number)
23638 Gilpin Point Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Preston | | 9c. COUNTY OF DEATH
Caroline | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Preston | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
23638 Gilpin Point Road | | | |
| 10f. ZIP CODE
21655 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) Seventh
College (1-4 or 5 +) | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Howard | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Clark Howard Fluharty | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Herman Steenken | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23638 Gilpin Point Rd., Preston, MD 21655 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Junior Order Cemetery 2-14 | | 20c. LOCATION — City or Town, State
Preston, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael J. Eskow | | 22. NAME AND ADDRESS OF FACILITY
Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 21632 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death
Days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James Sides M.D. | | 29c. LICENSE NUMBER
D31376 | | 29d. DATE SIGNED (Month, Day, Year)
2/14/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Sides, M.D., 920 Market Street, Denton, MD 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 95 | | 32. REGISTRAR'S SIGNATURE
Jane Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date.

Handwritten text, possibly a signature or date.

Handwritten text, possibly a signature or date.

Handwritten text, possibly a signature or date.

Handwritten text, possibly a signature or date.

95 06830

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JUDY MARIE STEPHENS | | | | 2. DATE OF DEATH
MONTH FEB. DAY 14 YEAR 1995 | | 3. TIME OF DEATH
2049 P M | |
| 4. SOCIAL SECURITY NUMBER
217-44-1055 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-25-1945 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | |
| 9c. COUNTY OF DEATH
WICOMICO | | | | 10a. STATE
MD. | | 10b. COUNTY
WICOMICO | |
| 10c. CITY, TOWN OR LOCATION
SALISBURY | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
3397 COULBOURNE MILL RD. | |
| 10f. ZIP CODE
21801 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (13-16 or 17+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
MAURICE CARMINE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
EDNA HEARN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JAMES C. STEPHENS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3397 COULBOURNE MILL RD. SALISBURY, MD. | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
WICOMICO MEMORIAL PARK 2-17 SALISBURY, MD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Gerald C. Bruner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BOUNDS FUNERAL HOME, SALISBURY, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic breast carcinoma
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: months | | | | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Janet Nasson MD</i> | | | | 29c. LICENSE NUMBER
D44999 | | 29d. DATE SIGNED (Month, Day, Year)
2/15/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JANET NASSON, MD 145 E. CARROLL ST SALISBURY, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06831

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ARLENE SEGEARS | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 4 YEAR 1995 | | 3. TIME OF DEATH
09:39 M | |
| 4. SOCIAL SECURITY NUMBER
579-74-5501 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-17-1956 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
PG MD | | | | 10b. COUNTY
PG | | 10c. CITY, TOWN OR LOCATION
Brentwood | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3300 42nd Ave. | | | |
| 10f. ZIP CODE
20722 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (6-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Nurses Aid | | 16b. KIND OF BUSINESS/INDUSTRY
Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lewis Horton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Grace Segears | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Grace McCoy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2919 Adams St., N.E. Washington DC 20018 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 2/10/95 | | 20c. LOCATION — City or Town, State
Landover, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Austin Royster Funeral Home 20010
3605 14th St., N.W. Washington DC | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → respiratory arrest | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): pneumonia | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): aspiration | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): regulated immune dysfunction syndrome | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic wasting syndrome | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D01499 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. LEWIS DENNIS | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(D)



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN A. SPRIGGS, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 09, 1995 | | 3. TIME OF DEATH
19:00 P M | |
| 4. SOCIAL SECURITY NUMBER
220-18-0694 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-7-25 | |
| 9a. FACILITY NAME (If not institution, give street and number)
12607 OAK GROVE RD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
UPPERMARBORO | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13607 Oak Grove Road | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: African-American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 6 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Farmhand | | 16b. KIND OF BUSINESS/INDUSTRY
Private | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John A. Spriggs, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen Conyers | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kathy A. Fletcher | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3405 Asher St, Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park Ceme. 2/16/95 Landover, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME
4001 Benning Rd. N.E., Wash. D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David Locke MD</i> | | | | 29c. LICENSE NUMBER
OCME | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 10, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ST. LAURENCE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text in the left margin, possibly a list or index, mostly illegible due to fading.

Main body of the document containing several paragraphs of handwritten text. The text is extremely faint and mostly illegible. Some fragments are visible, such as "The following" and "is a list of".



95 06833

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
VIOLA LYLE SNYDER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1995 | | 3. TIME OF DEATH
10:50 AM | |
| 4. SOCIAL SECURITY NUMBER
234-58-1256 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 yrs. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct 4, 1902 | |
| 8. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MD | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
220 Somerville Avenue | | | |
| 10f. ZIP CODE
21502 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Self-employed | | 17. KIND OF BUSINESS/INDUSTRY
Farming | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Snyder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lucinda (Park) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Stewart Cuppett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Keyser, WV | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Asbury Cemetery | | DATE
02/17 | | 20c. LOCATION — City or Town, State
Kirby, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James F. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Staphylococcal
b. Respiratory Infection
c.
d.

Approximate interval Between Onset and Death
10 Day
10 d
12 d | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia ASCVD/SICAF CVD
Prev. Cellulitis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Victor E. Mazzocco</i> | | | | 29c. LICENSE NUMBER
D07135 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 16, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. VICTOR E. MAZZOCCO, M.D., 912 SETON DRIVE, CUMBERLAND, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John D. Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #5, 2/15/95, W.D.L., Allegany Co.

95 06834

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PAUL DONALD SMITH | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11 1995 | | 3. TIME OF DEATH
M
04:26 am | |
| 4. SOCIAL SECURITY NUMBER
215-36-8799 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sep 7, 1939 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND, MD | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Cumberland | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
801 Hicks Avenue | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1963-1969 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Former Employee | | 16b. KIND OF BUSINESS/INDUSTRY
Allegany Technology | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Warren A. Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret (Wenrich) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ann M. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
801 Hicks Avenue; Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cem 02/14 | | 20c. LOCATION — City or Town, State
Flintstone, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jones Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. metastatic malignant melanoma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
3 mths | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
N. McCullough MD | | | | 29c. LICENSE NUMBER
D44712 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 14 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
N McCullough 902 Nton Drive Cumberland MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia L. ... | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Amended #106, 2/14/95, N.L.S. Allegany Co.

95 06835

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Leola NEILSON Spiker | | | | 2. DATE OF DEATH
MONTH February DAY 12 YEAR 1995 | | 3. TIME OF DEATH
7:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER
218-12-5077 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAR 22 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
233 Bynum Ridge Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Forest Hill | | 9c. COUNTY OF DEATH
MARYLAND | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
HARTFORD | | 10c. CITY, TOWN OR LOCATION
FOREST HILL | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
233 BYNUM RIDGE ROAD | | | |
| 10f. ZIP CODE
21050 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U S A | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) -- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
NURSES AIDE | | 16b. KIND OF BUSINESS/INDUSTRY
MEDICAL | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES GORDON NEILSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ELSIE DAVIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JOAN DESELL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
233 BYNUM RIDGE ROAD FOREST HILL, MD 21050 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FROSTBURG MEMORIAL PK FEB 15 | | 20c. LOCATION — City or Town, State
FROSTBURG, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Douglas A. Hafner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HAFFER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY LAVALE, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA (Transitional cell (Ductal))

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Home | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>D. L. Pirovolidis MD</i> | | | | 29c. LICENSE NUMBER
DO 9574 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
D. L. PIROVOLIDIS MD, 104 Plumtree Rd. Belair, Md. 21014 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06836

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
May R. Stran | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 21 1995 | | 3. TIME OF DEATH
10:00 p m | |
| 4. SOCIAL SECURITY NUMBER
220-44-9717 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
95 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 20, 1899 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Lorien Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Columbia | |
| 9c. COUNTY OF DEATH
Howard | | | | 10a. STATE
Maryland | | 10b. COUNTY
Howard | |
| 10c. CITY, TOWN OR LOCATION
Columbia | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
6334 Cedar Lane | | | | 10f. ZIP CODE
21045 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0-12
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Byron Phelps | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Donald S. Stran | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4276 Coattail Court, Ellicott City, Md. 21042 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodlawn | | DATE
2/24/95 | | 20c. LOCATION — City or Town, State
Woodlawn, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stanley Lawrence</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HARRY H. WITZKE FUNERAL HOME
4112 Old Columbia Pike, Ellicott City 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ISCHEMIC HEART DISEASE
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death
10 YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William Flowers MD</i> | | | | 29c. LICENSE NUMBER
D20708 | | 29d. DATE SIGNED (Month, Day, Year)
2/23/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Flowers MD 11055 Little Patuxent Columbia Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. H. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

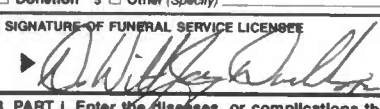
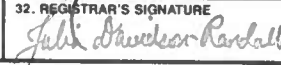
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
MAY 10 1964
U.S. AIR FORCE

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGE PARKER SOUDER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 20 1995 | | 3. TIME OF DEATH
7:15 P M | |
| 4. SOCIAL SECURITY NUMBER
579 - 16 - 6606 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 19, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
10130 HIGHRIDGE RD. | | 9b. CITY, TOWN OR LOCATION OF DEATH
LAUREL | |
| 9c. COUNTY OF DEATH
HOWARD | | | | 10a. STATE
Maryland | | 10b. COUNTY
Howard | |
| 10c. CITY, TOWN OR LOCATION
Laurel | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
10130 Highridge Road | |
| 10f. ZIP CODE
20723 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1942 - 1946 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 6 College (1-4 or 5+) Plumber | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Plumber | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | |
| 17. FATHER'S NAME (First, Middle, Last)
Edgar H. Souder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary A. Cook | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wehland Souder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9290 Old Scaggsville Rd, Laurel, Maryland 20723 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Emmanuel Cemetery | | 20c. LOCATION — City or Town, State
2/24 Scaggsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Theodore M. King M.D. | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB 21, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 24 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0950-005

B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/13/95 t.t

Amended #1, 2/27/95, M.W.O., Howard Co.

95 06838

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES C. STRANGE CHRISTOPHER C. STRANGE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 22 95 | | 3. TIME OF DEATH
6:46 PM | |
| 4. SOCIAL SECURITY NUMBER
212-64-5347 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
25 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
APR 28, 1969 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
6212 ETHEL AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH
CATONSVILLE | |
| 9c. COUNTY OF DEATH
BALTIMORE | | | | 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Catonsville | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
6212 Ethel Avenue | |
| 10f. ZIP CODE
21228 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Mechanical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
Electronics | |
| 17. FATHER'S NAME (First, Middle, Last)
Maxwell G. Strange | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ingrid Persano | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Maxwell G. Strange | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11710 Wayneridge Court Fulton MD 20759 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Balt-Washington Crematory Feb 27 | | 20c. LOCATION — City or Town, State
Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stanley Lawrence</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc
4112 Old Columbia Pike Ellicott City 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC AND COCAINE INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):
a. _____
b. _____
c. _____
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
FOUND 2-22-95 | | 28b. TIME OF INJURY
UNKNOWN M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
FOUND AT HOME | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
6212 ETHEL AVE. CATONSVILLE, MD. | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John Locke MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 23, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. LOCKE LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 27 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06839

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
TERESA (N.M.N.) SVITLIK | | | | 2. DATE OF DEATH
MONTH 2 DAY 17 YEAR 1995 | | 3. TIME OF DEATH
2328 P M | | |
| 4. SOCIAL SECURITY NUMBER
167-07-8076 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/30/1903 | | |
| 8. BIRTHPLACE (State or Foreign Country)
Czechoslovakia | | | | 9a. FACILITY NAME (If not institution, give street and number)
Carroll County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Westminster | | |
| 9c. COUNTY OF DEATH
Carroll | | | | 10a. STATE
Maryland | | 10b. COUNTY
Carroll | | |
| 10c. CITY, TOWN OR LOCATION
Finksburg | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
1503 Seminole Lane | | |
| 10f. ZIP CODE
21048 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | |
| 17. FATHER'S NAME (First, Middle, Last)
Michael Chromoho | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Priscilla (?) | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Bagwell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1503 Seminole Lane, Finksburg, MD 21048 | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St Peter & Paul Ukrainian 2/21/95 | | 20c. LOCATION — City or Town, State
Bakerton, PA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Kathrine Pitts-Switzer | | | | 22. NAME AND ADDRESS OF FACILITY
Pritts Funeral Home & Chapel
412 Washington Rd., Westminster, MD | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. ASPIRATION (RECURRENT)
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
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n.
o.
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zn.
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zp.
zq.
zr.
zs.
zt.
zu.
zv.
zw.
zx.
zy.
zz. | | | | | | | Approximate Interval Between Onset and Death
4 DAYS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SQUAMOUS CELL CANCER (LUNG?)
CONGESTIVE HEART FAILURE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Sally Spenscavage MD | | | | 29c. LICENSE NUMBER
D01079 | | 29d. DATE SIGNED (Month, Day, Year)
2/18/95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PARK W. SPENSCHADE, MD CARROLL COUNTY GENERAL HOSPITAL, WESTMINSTER, MD | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
Jane A. Anderson-Randall | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06840

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Larry Smith</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 10 1995 | | | | 3. TIME OF DEATH
1:43 P M | |
| 4. SOCIAL SECURITY NUMBER
577-72-7428 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 29, 1995 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | |
| 9a. FACILITY NAME (If not institution, give street and number)
Hyattsville Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
District of Columbia | | | | 10b. COUNTY
Washington | | | | 10c. CITY, TOWN OR LOCATION
Washington | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1811 East Capitol St., S.E. | | | | 10f. ZIP CODE
20003 | |
| 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) None | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
None | | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | 17. FATHER'S NAME (First, Middle, Last)
Willie Lee Smith | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marjorie E. Burke | | | | 19a. INFORMANT'S NAME (Type/Print)
Karen Y. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 Edmonston Dr., Rockville, MD 20851 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glenwood Cemetery 2/17/95 | | | | 20c. LOCATION — City or Town, State
Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart, III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Stewart Funeral Home
4001 Benning Rd., N.E. Wash., D.C. 20019 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acquired immune deficiency syndrome</i>
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. <i>Acquired immune deficiency syndrome</i>
b. <i>Diabetes</i>
c. <i>Hypertension</i>
d. <i>Chronic liver disease</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes, chronic liver disease, hypertension, chronic kidney disease</i> | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Lewis Dennis</i> | | | | 29c. LICENSE NUMBER
001499 | |
| 29d. DATE SIGNED (Month, Day, Year)
2/10/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH FORM 27 (Type/Print)
Dr. Lewis Dennis - 6201 Greenbelt Road, U-1 College Park, MD 20740-2356 | | | | 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

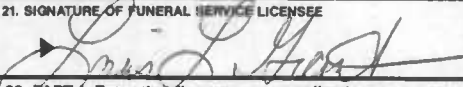
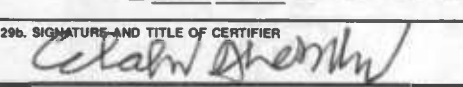
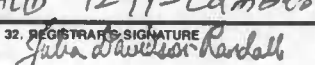
10g,
 AMENDED #190, & 22, 2/13/95, CYW, P.G. COUNTY

95 06841

1 - FOR
 STATE
 REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LILLIAN BEATRICE STRIET | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 4 YEAR 1995 | | 3. TIME OF DEATH
7:15 P.M. | |
| 4. SOCIAL SECURITY NUMBER
579-01-6010 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 12, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Ohio | | | | 9a. FACILITY NAME (If not Institution, give street and number)
Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | |
| 9c. COUNTY OF DEATH
Montgomery County | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Mount Rainier | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
4621 Eastern Avenue | |
| 10f. ZIP CODE
20712 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
John E. Goedel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Goedel | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John Bowman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4625 Eastern Avenue, Mount Rainier, MD 20712 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 2/7/95 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, MD 20722 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia
Approximate interval Between Onset and Death more than 2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D43496 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 7 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MOHAMMAD A. KHALIL 1299-Lamberton Drive Silver Spring MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14267

WASH BOND

FREE

95 06842

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
STEVENSON, ROBERT LOUIS | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 5 YEAR 1995 | | 3. TIME OF DEATH
9:05A | |
| 4. SOCIAL SECURITY NUMBER
579-74-1835 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
SEPT. 2, 1954 | |
| 9a. FACILITY NAME (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TAKOMA PARK | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
HYATTSVILLE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8108- 15th AVENUE #202 | | | | 10f. ZIP CODE
20783 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (14 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MUSICIAN | | 16b. KIND OF BUSINESS/INDUSTRY
PVT. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ROBERT LOUIS STEVENSON, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARGARET JOHNSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MARGARET STEVENSON/ MOTHER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8108-15th AVENUE #202 HYATTSVILLE, MARYLAND 20783 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATORY | | DATE
2-9 | | 20c. LOCATION — City or Town, State
BELTSVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Luwana L. Blaxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME 20785
7474 LANDOVER ROAD LANDOVER, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>cardiorespiratory failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>cardiomegaly</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>cardiomyopathy</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. <i>acquired immune deficiency syndrome</i> | | | | Approximate interval between Onset and Death
<i>8 days</i>
<i>5 weeks</i>
<i>1 year</i>
<i>1 year</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>chronic lymphocytic leukemia</i>
<i>metastatic carcinoma</i> | | | | | | | |
| 23a. WERE AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 23b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Lewis Dennis</i> | | | | 29c. LICENSE NUMBER
D01499 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 9/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. LEWIS DENNIS | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane Dawson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06843

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLARA SAYLOR | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 27 YEAR 1995 | | | | 3. TIME OF DEATH
3:20 A M | |
| 4. SOCIAL SECURITY NUMBER
273-26-9944 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH
(Month, Day, Year)
APRIL 21, 1911 | | | | 8. BIRTHPLACE (State or Foreign Country)
KENTUCKY | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEDLANTIC MANOR AT LAYHILL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
BROOKEVILLE | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER
19801 GEORGIA AVENUE | | | | 10f. ZIP CODE
20833 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM F. SAYLOR | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
MARTELIA OSBORNE | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
EVELYN YINGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19801 GEORGIA AVENUE BROOKEVILLE, MARYLAND 20833 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
PARKLAWN CEMETERY | | DATE
3/1 | | 20c. LOCATION — City or Town, State
ROCKVILLE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Muriel H. Barber</i> | | | | 22. NAME AND ADDRESS OF FACILITY
MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular Accident</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Peripheral Vascular Accident</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>Alzheimer's Disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death
<i>4 days</i>
<i>15 yrs.</i>
<i>10 yrs.</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M. Wejced Khan MD</i> | | | | | | | |
| 29c. LICENSE NUMBER
D32817 | | 29d. DATE SIGNED (Month, Day, Year)
FEBRUARY 27, 1995 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>M. Wejced Khan, MD, 12016 Georgia Ave, Wheaton, MD 20902</i> | | | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year)
MAR 02 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John A. H. H. H. H.</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NEW YORK PUBLIC LIBRARY

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1895

95 06844

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>ELMER L SHOPP, Sr.</u> | | | | 2. DATE OF DEATH
MONTH <u>February</u> DAY <u>24</u> YEAR <u>1995</u> | | 3. TIME OF DEATH
<u>2345</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>220-16-0125</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
<u>84</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>Jan 26 1911</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Washington County Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Hagerstown</u> | | 9c. COUNTY OF DEATH
<u>Washington</u> | |
| 10a. STATE
<u>MD</u> | | 10b. COUNTY
<u>Washington</u> | | 10c. CITY, TOWN OR LOCATION
<u>Big Pool</u> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>9432 Live Oak Lane</u> | | | | 10f. ZIP CODE
<u>21711</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Labor</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Construction</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Andrew Smith Shupp</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Bertha Staley</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Mary R. Shupp</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>9432 Live Oak Lane Big Pool, MD 21711</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Parkhead Cemetery Feb. 27, 95</u> | | 20c. LOCATION — City or Town, State
<u>Big Pool, MD</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Rice & Howe</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Grove Funeral Home
P.O. Box 368 Hancock, MD 21750</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>LUNG CANCER</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <u>PNEUMONIA</u>
c. <u>LUNG COLLAPSE</u>
d. <u>MYOCARDIAL INFARCTION</u> | | | | | | | Approximate Interval Between Onset and Death
<u>3 mths</u>
<u>1 month</u>
<u>1 month</u>
<u>1 month</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>GASTROINTESTINAL BLEED</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>SHAHAB Z. [Signature]</u> | | 29c. LICENSE NUMBER
<u>D45031</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>022595</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>19414 PORTSMOUTH DR HAGERSTOWN MD 21742</u> | | | | | | | |
| 31. DATE OF REGISTRATION
<u>MAR 06 1995</u> | | 32. REGISTRAR'S SIGNATURE
<u>John Andrew Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12
5/5/15

Amended #7, 2/23/95, SLW, Calvert Co.

95 06845

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Edward Smith | | | | 2. DATE OF DEATH
February 21 1995 | | 3. TIME OF DEATH
8:30 A M | |
| 4. SOCIAL SECURITY NUMBER
212 54 4057 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
October 19, 1950 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
LaPlata | |
| 9c. COUNTY OF DEATH
Charles | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Huntingtown | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
6100 Huntingtown Road | |
| 10f. ZIP CODE
20639 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
self employed/Home Improvement construction | |
| 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last)
James Smith | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Frances Louise Buckler | | 19a. INFORMANT'S NAME (Type/Print)
Thomas Smith | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10210 Mackall Rd. St. Leonard Maryland 20685 | | 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Waters Memorial February 23 1995 | | 20c. LOCATION — City or Town, State
St. Leonard Cal. Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
B. Rausch | | 22. NAME AND ADDRESS OF FACILITY
Rausch Funeral Home
4405 Broomes Is. Rd. Port Republic Maryland | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF LUNG
DUE TO (OR AS A CONSEQUENCE OF):
b. METASTATIC
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death
1 yr. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Rausch A. Mathur | | 29c. LICENSE NUMBER
D-28352 | |
| 29d. DATE SIGNED (Month, Day, Year)
2/21/95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Krishan Mathur, MD 11340 Pembroke Square Suite 213 Waldorf, MD 20603 | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | 32. REGISTRAR'S SIGNATURE
John Brandon Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06846

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Henry Scott, Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
02 16 95 | | 3. TIME OF DEATH
11:00p.m. | |
| 4. SOCIAL SECURITY NUMBER
717-07-5360 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-25-1902 | |
| 8. BIRTHPLACE (State or Foreign Country)
South Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number)
46 Red Toad Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
North East | |
| 9c. COUNTY OF DEATH
Cecil | | | | 10a. STATE
Maryland | | 10b. COUNTY
Cecil | |
| 10c. CITY, TOWN OR LOCATION
North East | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
46 Red Toad Road | |
| 10f. ZIP CODE
21901 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 1st
College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Chauffeur | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Scott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Cobb | | | |
| 19a. INFORMANT'S NAME (Type/Print)
McKinley Scott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 804, North East, Maryland 21901 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Carmel Cemetery | | 20c. LOCATION — City or Town, State
North East, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ernest M. Congo</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Ernest M. Congo Funeral Home
P.O. Box 2593, Wilmington, DE 19805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Natural Causes</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thomas E. Finucan</i> | | | | 29c. LICENSE NUMBER
D 32395 | | 29d. DATE SIGNED (Month, Day, Year)
02-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Thomas E. Finucan 3 Mauldin Avenue, North East, MD 21901 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
02-17-95
02-21-95 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> FEB 21 1995 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06847

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHANNON A. TOLAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 19 1995 | | 3. TIME OF DEATH
11:34 P M | |
| 4. SOCIAL SECURITY NUMBER
214-96-4343 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
14 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6/8/80 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Rte. 113 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | | 9c. COUNTY OF DEATH
WORCESTER | |
| 10a. STATE
MD | | | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Ocean City | |
| 10e. STREET AND NUMBER
10320 Bristol RD | | | | 10f. ZIP CODE
21842 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) Student | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
Student | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Daniel Nesbit Tolan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sheree Ann DeFelice | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Daniel Tolan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10320 Bristol RD Ocean City, MD 21842 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Sunset Memorial Park 2/23/95 | | 20c. LOCATION — City or Town, State
Berlin, MD | | 20d. DATE
2/23/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home
108 Williams St. Berlin, MD 21811 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Accident Scene | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2/19/95 | | 28b. TIME OF INJURY
2329 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED
Subject involved in motor vehicle accident | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Route 113 at Cedar Town Road | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Theodore M. King, M.D.</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 21, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 8, 172 18 2-21-95 OAN St. Mary's Co. 95 06848

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Earl Wilson Testerman | | | | 2. DATE OF DEATH
MONTH February DAY 11, YEAR 1995 | | | | 3. TIME OF DEATH
6:30 P M | |
| 4. SOCIAL SECURITY NUMBER
577-20-4489 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Mar 30, 1924 | | 8. BIRTHPLACE (State or Foreign Country)
Unknown | |
| 9a. FACILITY NAME (If not institution, give street and number)
Bayside Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lexington Park | | | | 9c. COUNTY OF DEATH
St. Mary's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
North Beach | | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
9131 Bay Avenue | | | | 10f. ZIP CODE
20714 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
Unknown | |
| 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Truck Driver | | | | 17. KIND OF BUSINESS/INDUSTRY
Trucking Company | | | | 18. DECEDENT'S FATHER'S NAME (First, Middle, Last)
Unknown | |
| 19. DECEDENT'S MOTHER'S NAME (First, Middle, Last)
Unknown | | | | 20. DECEDENT'S INFORMANT'S NAME (Type/Print)
Emma Louise Leake | | | | 21. DECEDENT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
155 Bend Farm Rd., Freckericksburg VA 22408 | |
| 22. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
Metropolitan Crematory | | | | 24. LOCATION — City or Town, State
Alexandria, Virginia | |
| 25. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael J. Gardiner | | | | 26. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. carcinoma Lung
DUE TO (OR AS A CONSEQUENCE OF):
c. cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 29. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
N/A | |
| 31. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 32. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 33. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| 34. DATE OF INJURY (Month, Day, Year) | | | | 35. TIME OF INJURY
M | | | | 36. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 37. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 38. DESCRIBE HOW INJURY OCCURRED | | | | 39. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 40. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 41. SIGNATURE AND TITLE OF CERTIFIER
B. M. E. | | | | 42. LICENSE NUMBER
D33470 | |
| 43. DATE SIGNED (Month, Day, Year)
2/13/95 | | | | 44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bhasker Jhaveri, M.D. Shanti Medical Center Leonardtown, Maryland 20650 | | | | 45. DATE FILED (Month, Day, Year)
FEB 21 1995 | |
| 46. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | |

95-0624-037

95-046

95 06849

blh

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM LAWRENCE THOMPSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 05 1995 | | 3. TIME OF DEATH
M
1556 | |
| 4. SOCIAL SECURITY NUMBER
215-46-0082 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 31, 1944 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
Route 5 (N) of Hill's Store | | 9b. CITY, TOWN OR LOCATION OF DEATH
Helen | |
| 9c. COUNTY OF DEATH
St. Mary's | | | | 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | |
| 10c. CITY, TOWN OR LOCATION
Avenue | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
P.O. Box 13 | |
| 10f. ZIP CODE
20609 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Woodcutter | | | | 16b. KIND OF BUSINESS/INDUSTRY
Lumber | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Thompson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Agnes Hayden | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 13, Avenue, Maryland 20609 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Sacred Heart | | 20c. LOCATION — City or Town, State
Bushwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Edward N. Brinsfield, Jr. M00052 | | | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries
DUE TO (OR AS A CONSEQUENCE OF):
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
2-5-95 | | 28b. TIME OF INJURY
1548 M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
Driver - Auto-Auto collision | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
RT 5 | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
OTL | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
Feb 06 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 09 1995 | | | | 32. REGISTRAR'S SIGNATURE
Jane Davidson-Hardall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06850

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
GABRIEL EDWARD THOMAS JR. | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 23 YEAR 1995 | | 3. TIME OF DEATH
2:35 A M | |
| 4. SOCIAL SECURITY NUMBER
577-24-8922 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 9, 1915 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON | | 9c. COUNTY OF DEATH
BALTIMORE | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Piney Point | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
P.O. Box 66 | | | | 10f. ZIP CODE
20674 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Machinist | | 16b. KIND OF BUSINESS/INDUSTRY
Electronics | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gabriel Edward Thomas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Myrtle Poe | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Fannie Mae Thomas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 66, Piney Point, Maryland 20674 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
St. George Episcopal Cemetery 2/25/95 | | 20c. LOCATION — City or Town, State
Valley Lee, Maryland | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, MD 20650 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Edward N. Brinsfield, Jr.</i>
Edward N. Brinsfield, Jr. M00052 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK (GRAM NEG RODS)
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DRUG-INDUCED CHOLESTASIS
DUE TO (OR AS A CONSEQUENCE OF):
c. DIABETES
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GASTRIC ULCER
CORONARY ARTERY DISEASE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mark C. Brinsfield, Jr. M.D.</i> | | | | 29c. LICENSE NUMBER
D 23832 | | 29d. DATE SIGNED (Month, Day, Year)
2/23/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GBMC | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 24 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Brinsfield</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06851

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MABLE TOWNSEND | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 8, 1995 | | 3. TIME OF DEATH
2:51pm M | |
| 4. SOCIAL SECURITY NUMBER
577-42-7690 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 1, 1906 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
Southern Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince Georges | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Fort Washington | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
7713 Loudon Drive | | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
African-American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Peter Davis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ida Stokes | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Leon Townsend | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7713 Loudon Dr. Ft. Washington Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington National Cem. | | 20c. LOCATION — City or Town, State
Arlington, Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Belva J. Jenkins | | | | 22. NAME AND ADDRESS OF FACILITY
Johnson & Jenkins Inc.
716 Kennedy St., N.W. Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Pulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Diabetes Mellitus
c. Hypercholesterolemia
d. }
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | Approximate Interval Between Onset and Death
15y- |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
K. Deuel MD. | | | | 29c. LICENSE NUMBER
D25642 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Khosraw - DAVACHI MD 1328 Southern Ave WASHINGTON DC 20032 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | 32. REGISTRAR'S SIGNATURE
John Davidson-Hardall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE

95 06852

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Otis G. Todd | | | | 2. DATE OF DEATH
MONTH Feb. DAY 13 YEAR 1995 | | 3. TIME OF DEATH
1800 M | |
| 4. SOCIAL SECURITY NUMBER
577-76-7453 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
APRIL 2, 1957 | |
| 9a. FACILITY NAME (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TAKOMA PARK | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
LANDOVER | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7711 MUNCY ROAD | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12th College (1-4 or 5+) CUSTODIAN | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
GOVT. | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
OTIS TODD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ERNESTINE WARREN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CECELIA TODD/ WIFE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7711 MUNCY ROAD LANDOVER, MARYLAND 20785 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK 2-18 | | 20c. LOCATION — City or Town, State
LANDOVER, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Shawana Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME 20785
7474 LANDOVER ROAD LANDOVER, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquired immune deficiency syndrome
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
unk |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic renal insufficiency, nephropathy | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
DOW 99 | | 29d. DATE SIGNED (Month, Day, Year)
2/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
6201 GREENBELT RD COLLEGE PARK, MD 20740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


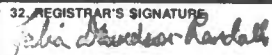
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06853

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Merle Kenneth Turney, Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 11, 1995 | | 3. TIME OF DEATH
11:30 P M | |
| 4. SOCIAL SECURITY NUMBER
196-18-4941 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (in yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec 1, 1923 | |
| 9a. FACILITY NAME (if not institution, give street and number)
HCR, Box 4, | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Friendsville | | 9c. COUNTY OF DEATH
Garrett | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Garrett | | 10c. CITY, TOWN OR LOCATION
Friendsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
HCR, Box 4 | | | | 10f. ZIP CODE
21531 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Equipment Operator | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Earl Turney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Esther Hanft | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Betty E. Turney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HCR, Box 4, Friendsville, MD 21531 | | | |
| 20a. MANNER OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Steele Cemetery 2-15-95 | | 20c. LOCATION — City or Town, State
Friendsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Newman Funeral homes, P.A.
155 Main St., Grantsville, MD 21536 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Transitional Cell Carcinoma | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease, Diabetes | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident
3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John T. Turski III D.O. | | | | 29c. LICENSE NUMBER
H37232 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 13 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John T Turski III, D.O. PO Box 67 Friendsville MD 21531 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|---|--|---|--|----|---------------------------------|----------------|----|---|-----------------|----|--|--|----|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM R THAMES, Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 18, 1995 | | 3. TIME OF DEATH
9:15PM | | | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
577-22-3752 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 29, 1919 | | | | | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Anne Arundel General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Annapolis | | 9c. COUNTY OF DEATH
Anne Arundel | | | | | | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Lothian | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| 10e. STREET AND NUMBER
117 Patuxent Mobile Estates | | | | 10f. ZIP CODE
20711 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Sanitary Disposal | | 16b. KIND OF BUSINESS/INDUSTRY
Self-employed | | | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Thomas Thames | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Greenwell | | | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Betty Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
117 Patuxent Mobile Estates Lothian Md. 20711 | | | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 1995 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Rd Clinton, Md 20735 | | | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<table border="0"> <tr> <td>a.</td> <td>CONGESTIVE HEART FAILURE</td> <td>2 YEARS</td> </tr> <tr> <td>b.</td> <td>CHRONIC OBSTRUCTIVE LUNG DISEASE</td> <td>10 YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | a. | CONGESTIVE HEART FAILURE | 2 YEARS | b. | CHRONIC OBSTRUCTIVE LUNG DISEASE | 10 YEARS | c. | | | d. | | |
| a. | CONGESTIVE HEART FAILURE | 2 YEARS | | | | | | | | | | | | | | | | | |
| b. | CHRONIC OBSTRUCTIVE LUNG DISEASE | 10 YEARS | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
VENTRICULAR ARRHYTHMIA | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | | | | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>L. K. Essandoh MD</i> | | | | 29c. LICENSE NUMBER
D41417 | | 29d. DATE SIGNED (Month, Day, Year)
2-19-95 | | | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
180 ADMIRAL COCHRANE DR. L. K. ESSANDOH MD ANNAPOLIS MD 21401 | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06855

AMENDED #19a, 22, 2/13/95, CYW, P.G. COUNTY

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Tisdale, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 7, 1995 | | | | 3. TIME OF DEATH
8:20 P. M | | | |
| 4. SOCIAL SECURITY NUMBER
579-66-7072 | | | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
45 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 2, 1949 | | 8. BIRTHPLACE (State or Foreign Country)
South Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number)
Hyattsville Manor Home | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Cheverly | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10a. STREET AND NUMBER
3408 Cheverly Avenue | | | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Transportation Aide | | | | 15b. KIND OF BUSINESS/INDUSTRY
Federal Government | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Tisdale, Sr. | | | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Vernnie Lee Lewis | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Edna Edward Burns, Jr. | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
415 G Street, S.W., Washington, D.C. 20024 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Abigail Cemetery 2/11/95 | | 20c. LOCATION — City or Town, State
Longs, South Carolina | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | | | 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, MD 20722 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | |
| e. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 3 DAYS | |
| b. MYCOBACTERIUM AVIUM INTRACELLULARE PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 3 WEEKS | |
| c. ENCEPHALOPATHY
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | UNKNOWN | |
| d. ACQUIRED IMMUNE DEFICIENCY SYNDROME | | | | | | | | | | UNKNOWN | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
pancytopenia, wasting syndrome, insulin dependent
diabetes mellitus | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | | | 29c. LICENSE NUMBER
D01499 | | 29d. DATE SIGNED (Month, Day, Year)
02-08-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. LEWIS HILLIARD DENNIS 6201 GREENBELT RD #U-1 COLLEGE PARK, MD 20740 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06856

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GERTRUDE CONSTANTINE VERMEULE | | | | 2. DATE OF DEATH
MONTH February DAY 17 YEAR 1995 | | 3. TIME OF DEATH
12:25 A M | |
| 4. SOCIAL SECURITY NUMBER
218-38-9084 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
2-8-01 | |
| 9a. FACILITY NAME (If not Institution, give street and number)
BERLIN NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BERLIN | | 9c. COUNTY OF DEATH
WORCESTER | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
DELAWARE | | 10b. COUNTY
SUSSEX | | 10c. CITY, TOWN OR LOCATION
SOUTH BETHANY | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
302 YORK ROAD | | | | 10f. ZIP CODE
19930 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW I | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
ACCOUNTANT | | 15b. KIND OF BUSINESS/INDUSTRY
US GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last)
HENRY CONSTANTINE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY E. DANIELS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CLARA E. PONTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
302 YORK RD. S. BETHANY, DEL., 19930 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SALISBURY CREMATORY DATE 2/19 | | 20c. LOCATION — City or Town, State
SALISBURY, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
ULLRICH FUNERAL HOME BERLIN, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | |
| | | b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | |
| | | c. SENILE DEMENTIA | | | | | |
| | | d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D46257 | | 29d. DATE SIGNED (Month, Day, Year)
2/17/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Edwin Castaneda MD 7187 Bent Pine Rd. Willards MD 21874 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06857

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
I. DALLAS VEASEY | | | | 2. DATE OF DEATH
MONTH February DAY 6 YEAR 1995 | | | | 3. TIME OF DEATH
02:55 M | | |
| 4. SOCIAL SECURITY NUMBER
222-22-1918 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
57 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | | | 9c. COUNTY OF DEATH
WICOMICO | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE
DELAWARE | | 10b. COUNTY
SUSSEX | | 10c. CITY, TOWN OR LOCATION
REHOBOTH | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
320 AIRPORT ROAD | | | | 10f. ZIP CODE
19971 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
N/A | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
BARTENDER | | | 16b. KIND OF BUSINESS/INDUSTRY
TAVERN | | | |
| 17. FATHER'S NAME (First, Middle, Last)
COURTLAND VEASEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ETHEL BETTS | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. GEORGE CLARK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BOX 34 A ORCHARD MANOR, MILLSBORO DE 19966 | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of place, date, time)
HELEN OPEN MEMORIAL PARK 2-9 | | 20c. LOCATION — City or Town, State
MILTON, DE | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
George M. Stolt | | | | 22. NAME AND ADDRESS OF FACILITY
SHORT FUNERAL SERVICES INC
PO BOX 233, MILTON, DE 19968 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Squamous Cell Carcinoma of
DUE TO (OR AS A CONSEQUENCE OF):
b. Pyiform Sinus
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James E. Martin, M.D. | | | | 29c. LICENSE NUMBER
030690 | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 6, 1995 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD. | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)
<i>Joan Marie Vita</i> | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>February 12, 1995</i> | | 3. TIME OF DEATH
<i>6:30 P</i> |
| 4. SOCIAL SECURITY NUMBER
<i>219-68-3049</i> | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>37</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Jan. 11, 1958</i> |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>7509 Newberry Lane</i> | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>New Carrollton</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Washington, DC</i> |
| RESIDENCE OF DECEASED | | | 9c. COUNTY OF DEATH
<i>Prince George's</i> | | |
| 10a. STATE
<i>Maryland</i> | 10b. COUNTY
<i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION
<i>Lanham</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 10e. STREET AND NUMBER
<i>7509 Newberry Lane</i> | | | 10f. ZIP CODE
<i>20706</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEASED'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | 16a. DECEASED'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Secretary</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Private Industry</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>William J. Vita, Jr.</i> | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Dolores Ann Schwartz</i> | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>William J. Vita, Jr.</i> | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>7509 Newberry Lane, Lanham, Maryland 20706</i> | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Fort Lincoln Cemetery 02/15/95</i> | | 20c. LOCATION — City or Town, State
<i>Brentwood, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles F. Bell</i> | | 22. NAME AND ADDRESS OF FACILITY
<i>Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Asphyxia</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | Approximate Interval Between Onset and Death
<i>Months</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
<i>2-12-95</i> | | 28b. TIME OF INJURY
<i>P</i> | |
| | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
<i>hung self</i> | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<i>Residence fireplace room, 7509 Newberry Lane, Prince Georges MD</i> | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Augusto P. Rodriguez MD</i> | | | |
| | | 29c. LICENSE NUMBER
<i>D21230</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>February 12, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i> | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 14 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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95 06859

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Leonila C. Villafuerte | | | | 2. DATE OF DEATH
MONTH February DAY 12, 1995 YEAR 1995 | | 3. TIME OF DEATH
1:15 P. M | |
| 4. SOCIAL SECURITY NUMBER
577-19-6132 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
80 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
June 10, 1914 | 8. BIRTHPLACE (State or Foreign Country)
Philippines | | |
| 9a. FACILITY NAME (If not institution, give street and number)
6275 Oxon Hill Road, Apt. 204 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Oxon Hill | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Oxon Hill | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6275 Oxon Hill Road #204 | | | | 10f. ZIP CODE
20745 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Filipino | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Jose Castor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alejandra Fulgencio | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ofelia Mercado | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6275 Oxon Hill Rd. #204 Oxon Hill, Md. 20745 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 2-14-95 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Arteriosclerotic cardiovascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death
years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D 21230 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 12, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Augusto P. Rodriguez, M.D. 5009 Rayburn Court, Camp Springs, Md. 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06860

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Elsie Wood | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 21, 1995 | | 3. TIME OF DEATH
4:03 p.m. | |
| 4. SOCIAL SECURITY NUMBER
220-16-8548 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Apr. 4, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | 9c. COUNTY OF DEATH
St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
California | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1041 North Patuxent Beach Road | | | | 10f. ZIP CODE
20619 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8th Grade | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Rowen Buckler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Laura Lee Woodburn | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Catherine M. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1041 N. Patuxent Beach Rd., California, MD 20619 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Zion Un. Methodist Cem 2/24/95 | | 20c. LOCATION — City or Town, State
Mechanicsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Resp Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Urinary tract Infection
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Bhasker Jhaveri</i> | | | | 29c. LICENSE NUMBER
D33470 | | 29d. DATE SIGNED (Month, Day, Year)
2/22/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bhasker Jhaveri, M.D. Shanti Medical Center, Leonardtown, MD 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 23 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06861

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Thomas Alvin Womack Jr. | | 2. DATE OF DEATH
MONTH DAY YEAR
February 20, 1995 | | 3. TIME OF DEATH
1014 M | |
| 4. SOCIAL SECURITY NUMBER
211-28-1897 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year)
September 29, 1936 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Patuxent River Naval Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Patuxent River | | 9c. COUNTY OF DEATH
St. Marys | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Lexington Park | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
#3 Majestic Court | | 10f. ZIP CODE
20653 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Vietnam | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Noncommissioned Officer | | 15b. KIND OF BUSINESS/INDUSTRY
U.S. Navy/Defense | |
| 17. FATHER'S NAME (First, Middle, Last)
Maxie Womack | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Hattie Womack | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#3 Majestic Court, Lexington Park, Maryland 20653 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Kings Memorial Cemetery 2/25/95 | | 20c. LOCATION — City or Town, State
Baltimore | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael K. Blankenship | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Cancer of the Pancreas</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
N/A | | 28b. TIME OF INJURY
N/A M | |
| | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
N/A | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
N/A | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
William D. Boyd II, M.D. | | 29c. LICENSE NUMBER
014285 | | 29d. DATE SIGNED (Month, Day, Year)
2-20-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William D. Boyd II, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650 | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 22 1995 | | 32. REGISTRAR'S SIGNATURE
John D. Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06862

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Lucy Yvonne Wood | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 18, 1995 | | 3. TIME OF DEATH
8:07 P M | |
| 4. SOCIAL SECURITY NUMBER
216-27-1536 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug 25, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtwn | | 9c. COUNTY OF DEATH
St. Mary's | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Mechanicsville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3860 Baptist Church Road | | | | 10f. ZIP CODE
20659 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEASED'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12th Grade | | 15a. DECEASED'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Quincy Cusic | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nora Catherine Bussler | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Emily W. Norris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3890 Baptist Church Rd., Mechanicsville, MD 20659 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Queen of Peace Cemetery 2/21/95 | | 20c. LOCATION — City or Town, State
Helen, Maryland | | 20d. DATE
2/21/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael L. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sudden Death - Prob Acute Myocardial Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David C. Allen</i> | | | | 29c. LICENSE NUMBER
D25236 | | 29d. DATE SIGNED (Month, Day, Year)
2/21/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David C. Allen, M.D. Leonardtown, Maryland 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


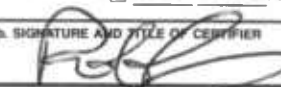
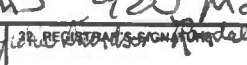
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06863

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles Lawrence Walls | | | | 2. DATE OF DEATH
MONTH February DAY 2 YEAR 95 | | 3. TIME OF DEATH
7:30 P M | |
| 4. SOCIAL SECURITY NUMBER
213-12-5782 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 16 1915 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. COUNTY OF DEATH
Talbot | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Greensboro | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
102 New Street | | | | 10f. ZIP CODE
21639 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
4th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
assembly line | | 16b. KIND OF BUSINESS/INDUSTRY
Globe Union Company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Walls | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mammie Morgan Walls | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ethel K. Walls | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
102 New Street Greensboro, MD 21639 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Mt. Olive Cemetery | | 20c. LOCATION — City or Town, State
2/5 Sandtown, Delaware | | 22. NAME AND ADDRESS OF FACILITY
Fleegle-Helfenbein Funeral Home
P.O. Box 160 Greensboro, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Fleegle-Helfenbein Funeral Home
P.O. Box 160 Greensboro, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
1 hour | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
1 hour | |
| | | c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
↑BP, DJD | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D33294 | | 29d. DATE SIGNED (Month, Day, Year)
2/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Rob Lappin MD 920 Market St. Denton, Md. 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 95 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06864

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JEANNETTE MARIE WHITCRAFT | | | | 2. DATE OF DEATH
MONTH 02 DAY 13 YEAR 95 | | 3. TIME OF DEATH
1645 M | |
| 4. SOCIAL SECURITY NUMBER
214 96 9349 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
19 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 31, 1975 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Frederick Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Frederick | | 9c. COUNTY OF DEATH
Frederick | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Monrovia | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3120 Will-Mil Terrace | | | | 10f. ZIP CODE
21770 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 1/2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
School | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Carl V. Whitcraft Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sharon McDonald | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sharon McDonald | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3120 Will-Mil Terrace Monrovia Md. 21770 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens 2/16/95 | | 20c. LOCATION — City or Town, State
Davidsonville Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARBON MONOXIDE
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
02/13/95 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED
INCARE HOSE TO EXHAUST | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
ATTACHED GARAGE - HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
130116 LAMALL BROS RD MONROVIA 21770 | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert R R Rohate | | | | 29c. LICENSE NUMBER
D09867 | | 29d. DATE SIGNED (Month, Day, Year)
01/13/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
1547TH ST FREDERICK MD 21701-4599 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06865

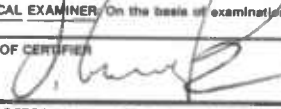
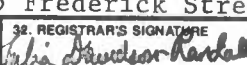
1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
VELMA GAMBLE WRIGHT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 13 95 | | 3. TIME OF DEATH
20:40 PM | |
| 4. SOCIAL SECURITY NUMBER
212242242 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV. 24, 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MEMORIAL HOSPITAL & MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CUMBERLAND | | 9c. COUNTY OF DEATH
ALLEGANY | |
| 10a. STATE
MD | | 10b. COUNTY
ALLEGANY | | 10c. CITY, TOWN OR LOCATION
MOUNT SAVAGE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
15929 FOUNDRY ROAD | | | | 10f. ZIP CODE
21545 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ROBERT CHARLES GAMBLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
EMMA PATTERSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
FLOYD WRIGHT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
329 NOTTINGHAM RD, HAGERSTOWN, MD 21740 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
RESTLAWN MEM. PARK FEB 17, 1995 | | 20c. LOCATION — City or Town, State
LaVALE, MD 21502 | | 20d. DATE
FEB 17, 1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
HARVEY H. ZEIGLER FUNERAL HOME
HYNDMAN, PA 15545-0636 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF): Senile dementia
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Angina | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY (home, farm, street, factory, office building, etc. (Specify)) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D 36766 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 17 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. VIK POONAI, 455 Frederick Street, Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 16 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06866

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
AGNES B. WINTERMYER | | | | 2. DATE OF DEATH
MONTH Jan. DAY 19 , YEAR 1995 | | 3. TIME OF DEATH
0321 A. M | |
| 4. SOCIAL SECURITY NUMBER
214-07-5963 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
Nov 21, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number)
FROSTBURG COMMUNITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
FROSTBURG | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
LaVale | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
408 National Highway | | | | 10f. ZIP CODE
21502 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Bobbin Stores | | 16b. KIND OF BUSINESS/INDUSTRY
Textile | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Bryson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bridget (Cullen) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Layman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
202 Braddock Heights; Frostburg, MD 21532 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens | | DATE
01/21 | | 20c. LOCATION — City or Town, State
LaVale, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
James F. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. aspiration pneumonia
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Dysphagia
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. Stroke
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. Arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
Dementia | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
George Breza MD | | | | 29c. LICENSE NUMBER
D12532 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 14, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
George Breza, M.D. 912 Seton Drive; Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 15 1995 | | | | 32. REGISTRAR'S SIGNATURE
Johanna Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

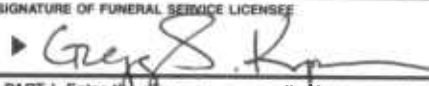
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06867

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JEANNE E WILKIE | | | | 2. DATE OF DEATH
MONTH FEB DAY 22 YEAR 1995 | | 3. TIME OF DEATH
8:30 AM | |
| 4. SOCIAL SECURITY NUMBER
097-12-9367 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 16, 1922 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Laurel Regional Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | 9c. COUNTY OF DEATH
Prince George | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George | | 10c. CITY, TOWN OR LOCATION
Laurel | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7107 Carriage Hill Drive | | | | 10f. ZIP CODE
20707 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Ratings Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George Mundt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Bin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anne Leney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7107 Carriage Hill Drive Laurel, Maryland 20707 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory | | DATE
2/23 | | 20c. LOCATION — City or Town, State
Catonsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home P.A.
313 Talbott Avenue Laurel, Md. 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. CONGESTIVE CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
c. ISCHAEMIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
3 yrs
3 yrs
14 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS, RENAL FAILURE;
LUNG CARCINOMA BOTH LUNGS
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
C. Delima MD | | | | 29c. LICENSE NUMBER
D 22755 | | 29d. DATE SIGNED (Month, Day, Year)
2-22-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHRISTINE DELIMA 5120 CONTEE RD #260 LAUREL MD 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 24 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06868

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
INA MARIE WAREHIME | | | | 2. DATE OF DEATH
MONTH 2 DAY 30 YEAR 95 | | 3. TIME OF DEATH
815P M | |
| 4. SOCIAL SECURITY NUMBER
215-58-2683 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/5/1900 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Manchester | | 9c. COUNTY OF DEATH
Carroll | |
| 6a. FACILITY NAME (If not institution, give street and number)
Long View Nursing Home | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Carroll | | 10c. CITY, TOWN OR LOCATION
Manchester | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3332 Main Street | | | | 10f. ZIP CODE
21102 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
10 Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George A. Shipley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emily Wagner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dorothy Warehime | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157
7 Middle Grove Court, Westminster, MD | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Deer Park Church Cemetery | | 20c. LOCATION — City or Town, State
Westminster, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Katharine Pritts-Sweitzer | | | | 22. NAME AND ADDRESS OF FACILITY
Pritts Funeral Home & Chapel
412 Washington Rd., Westminster, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
a. Cerebral Vascular Accident
b.
c.
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death
2 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia
arterio Sclerosis Hypertension | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
W H FORD MD | | | |
| 29c. LICENSE NUMBER
D02386 | | | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. H. FORD MD 3223 MAIN ST MANCHESTER, MD 21102 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
J. H. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

SECTION 1

RECEIVED

SECTION 1

95 06869

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGIE MARTIN WINTER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 17, 1995 | | 3. TIME OF DEATH
5:58P M | |
| 4. SOCIAL SECURITY NUMBER
225-01-9538 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb 13, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
PHYSICIANS MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
LA PLATA | |
| 9c. COUNTY OF DEATH
CHARLES | | | | 10a. STATE
Maryland | | 10b. COUNTY
Charles | |
| 10c. CITY, TOWN OR LOCATION
Waldorf | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
3502 Sugar Maple Court | |
| 10f. ZIP CODE
20602 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Cafeteria Manager | | 16b. KIND OF BUSINESS/INDUSTRY
P.G. Board of Education | |
| 17. FATHER'S NAME (First, Middle, Last)
Westley A. Martin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lila Vest | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wesley C. Winter (Son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3502 Sugar Maple Court, Waldorf, Md 20602 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Ce, m. Feb 20, 1995 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles L. Belonger | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK
DUE TO (OR AS A CONSEQUENCE OF):
b. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
2 hrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
R. Math | | | | 29c. LICENSE NUMBER
D-28352 | | 29d. DATE SIGNED (Month, Day, Year)
2/18/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KRISHAN MATHUR, MD. 11340 PEMBROOKE SQUARE SUITE 213 WALDORF, MARYLAND | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Emily GRIMES WALTON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 20, 1995 | | 3. TIME OF DEATH
2:13 A | |
| 4. SOCIAL SECURITY NUMBER
212-20-1708 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 12, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Suitland | |
| 10e. STREET AND NUMBER
3940 Bexley Place Apt. 302 | | | | 10f. ZIP CODE
20764 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Title Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Automotive | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Owen NMN Grimes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pearl Wilson Cage | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeffrey A. Walton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9410 James Court, Pomfret, MD 20675 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Trinity Memorial Gardens 2-23 | | DATE
Waldorf, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Shirley Caporaletti M00844 | | | | 22. NAME AND ADDRESS OF FACILITY
Hunt Funeral Home
P. O. Box 156, Waldorf, MD 20604-0156 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute respiratory distress syndrome
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. urinary tract infection
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
3 weeks
4 weeks
6 weeks |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive cerebrovascular disease
mitral regurgitation, Renal failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
IV [Signature] | | | | 29c. LICENSE NUMBER
D38388 | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SUNIL NACHWANI M.D. 8926 WOODYAROD #601 CLINTON, MARYLAND 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
John [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06871

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Caroline Virginia Washington | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 6, 1995 | | 3. TIME OF DEATH
3:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER
228-52-8786 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 4, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
Manor Care Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Largo | |
| 9c. COUNTY OF DEATH
Prince George | | | | 10a. STATE
Md | | 10b. COUNTY
Prince Georges | |
| 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
12011 Chesterton Drive | |
| 10f. ZIP CODE
20772 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Domestic | |
| 17. FATHER'S NAME (First, Middle, Last)
William Henry Ball | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mariah Jackson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Henry Russell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12011 Chesterton Dr. Upper Marlboro, Md 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington Crematory 12/10 | | 20c. LOCATION — City or Town, State
Arlington, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
George W. Joynes | | | | 22. NAME AND ADDRESS OF FACILITY
Joynes Funeral Home
35 N. 3rd St. Warrington Va. 22186 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Metastatic Colon Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia Diabetes | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Sam Tellair | | | | 29c. LICENSE NUMBER
D34274 | | 29d. DATE SIGNED (Month, Day, Year)
2/9/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Sam Tellair 4000 Mitchellville Rd. Bowie Md. 20721 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06872

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM CLIFTON WHITE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 3, 1995 | | 3. TIME OF DEATH
12:17 P | |
| 4. SOCIAL SECURITY NUMBER
218-34-5193 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
57 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
OCT. 26, 1937 | |
| 9a. FACILITY NAME (If not institution, give street and number)
4275-58th STREET #t2 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BLADENSBURG | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
BLADENSBURG | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4275-58th STREET #t2 | | | |
| 10f. ZIP CODE
20710 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES ARMY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY
PVT. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
CHARLIE NATT WHITE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
NANCY BELL BRACY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBIN WILLIAMS/ DAUGHTER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6708 MILITOWN COURT DISTRICT HEIGHTS, MARYLAND 20747 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MARYLAND VETERANS CEM. | | 20c. LOCATION — City or Town, State
2-13 CHELTENHAM, MARYLAND | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Shawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer of the larynx</i> | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Schizophrenia</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jeffrey Wall, M.D.</i> | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALBINO WALKER, M.D. 10701 TRAFLET DR., LARGO, MD 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27 PER MEO -4/6/95 re G-722

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHIRLEY WILLIAMS | | | | 2. DATE OF DEATH
MONTH FEB DAY 07 YEAR 1995 | | 3. TIME OF DEATH
18:51 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
216-50-8081 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
52 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JUNE 29, 1942 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
BOWIE HEALTH CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BOWIE | | | 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
UPPER MARLBORO | | | 10d. INSIDE CITY LIMITS?
1 X YES 2 NO | | | | | | |
| 10e. STREET AND NUMBER
17116 FAIRWAY VIEW LANE | | | | 10f. ZIP CODE
20772 | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | |
| 11. MARITAL STATUS
1 Never Married 2 X Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JOSEPH GALLOWAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LAURA WARNER | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CHARLES E. WILLIAMS/HUSBAND | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17116 FAIRWAY VIEW LANE UPPER MARLBORO, MD 20772 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or burial place)
WASHINGTON NATIONAL CEM. 2-13 | | 20c. LOCATION — City or Town, State
SUITLAND, MARYLAND | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Thawana L. Braxton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME
7474 LANDOVER ROAD LANDOVER, MD 20785 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 X YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 X YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 X ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
2 X MEDICAL EXAMINER | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thawana L. Braxton</i>
OCME | | | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
FEB.08, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THE MORE M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06874

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Donald Ferrell Young | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 3, 1995 | | 3. TIME OF DEATH
7:30 A M | |
| 4. SOCIAL SECURITY NUMBER
225-52-3772 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
September 14, 1939 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9. COUNTY OF DEATH
St. Mary's | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
St. Mary's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Leonardtown | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
St. Mary's | | 10c. CITY, TOWN OR LOCATION
Mechanicsville | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2830 Yowaiski Mill Road | | | |
| 10f. ZIP CODE
20659 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Steam Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
Medical | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Donald Young | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lockie Stiltner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Fannie DeTos Young | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2830 Yowaiski Mill Road, Mechanicsville, MD 20659 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Charles Memorial 2-7-95 | | 20c. LOCATION — City or Town, State
Leonardtown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Edward N. Brinsfield, Jr.</i> | | 22. NAME AND ADDRESS OF FACILITY
Brinsfield Funeral Home
P.O. Box 279, Leonardtown, MD 20650 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>Myocardial infarct</i>
a. DUE TO (OR AS A CONSEQUENCE OF):
<i>atherosclerotic cardiovascular disease</i>
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>D. Allen</i> | | 29c. LICENSE NUMBER
D22574 | | 29d. DATE SIGNED (Month, Day, Year)
2/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
C. Timothy Pace, M.D. Suite G, Eye-Care Bldg., Waldorf, Maryland 20601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-06875

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Lillard C. Yeatts</i> | | | | 2. DATE OF DEATH
<i>February 13, 1995</i> | | | | 3. TIME OF DEATH
<i>110 A</i> | | |
| 4. SOCIAL SECURITY NUMBER
<i>228 40 6505</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>60</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Dec. 11, 1934</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Virginia</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>9301 Merkel Farm Rd.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Bowie</i> | | | | 9c. COUNTY OF DEATH
<i>Prince George's</i> | | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION
<i>Bowie</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
<i>9301 Markel Farm Road</i> | | | | 10f. ZIP CODE
<i>20715</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<i>No</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>No</i> | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<i>Elementary/Secondary (9-12)</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Superintendent</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Building</i> | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Ralph Yeatts</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Sally Lovell</i> | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Shirley H. Yeatts</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>9301 Merkel Farm Road Bowie Maryland 20715</i> | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Fort Lincoln Cemetery</i> | | DATE
<i>February 13, 1995</i> | | 20c. LOCATION — City or Town, State
<i>Brentwood Maryland</i> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert E. Evans Pres.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715</i> | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Asphyxia</i>
DUE TO (OR AS A CONSEQUENCE OF):

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death
<i>70 minutes</i> | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
<i>2/12/95</i> | | 28b. TIME OF INJURY
<i>11 P</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
<i>Lung self</i> | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<i>Residence, garage, 9301 Merkel Farm Rd, Prince Md</i> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<i>9301 Merkel Farm Rd, Prince Md</i> | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Augusto P. Rodriguez M.D.</i> | | | | | | 29c. LICENSE NUMBER
<i>D21230</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>February 13, 1995</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 15 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane A. ...</i> | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


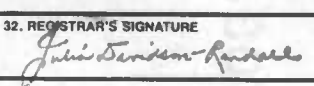
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06876

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Aloysius Bernard Zilliox, Jr. | | | | 2. DATE OF DEATH
MONTH Feb. DAY 14. YEAR 1995 | | 3. TIME OF DEATH
6:00PM | |
| 4. SOCIAL SECURITY NUMBER
182-12-2763 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6/5/25 | |
| 9a. FACILITY NAME (If not institution, give street and number)
203 N. Dorchester St. Apt. 2A | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Ocean City | | 9c. COUNTY OF DEATH
Worcester | |
| 10a. STATE
MD | | | | 10b. COUNTY
Worcester | | 10c. CITY, TOWN OR LOCATION
Ocean City | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
203 N. Dorchester St. Apt. 2A | | | |
| 10f. ZIP CODE
21842 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Plumber | | 16b. KIND OF BUSINESS/INDUSTRY
Plumbing | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Aloysius Bernard Zilliox, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Martha Helbling | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dolores DiMeo | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
568 Claymont Dr. Lexington, KY 40503 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cape Henlopen Crematory 2/17/95 | | 20c. LOCATION — City or Town, State
Frankford, DE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Burbage Funeral Home 108 Williams St. Berlin, MD 21811 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malnutrition
DUE TO (OR AS A CONSEQUENCE OF):
b. Alcoholism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D06241 | | 29d. DATE SIGNED (Month, Day, Year)
2-17-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Dorothy C. Holzworth, M.D. 203 Snow St. Snow Hill, MD 21863 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 17 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


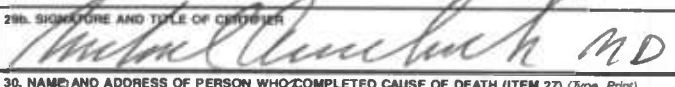
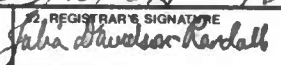
SECRET

SECRET

95 06877

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Nancy Wyatt Zellers | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 17, 1995 | | 3. TIME OF DEATH
4:05P M | |
| 4. SOCIAL SECURITY NUMBER
213-38-7168 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
01-29-1942 | |
| 9a. FACILITY NAME (If not institution, give street and number)
11 York Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Port Deposit | | 9c. COUNTY OF DEATH
Cecil | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Port Deposit | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11 York Drive | | | | 10f. ZIP CODE
21904 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Walter Wyatt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mallisia I. Blevins | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Leonard W. Zellers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 York Drive, Port Deposit, MD 21904 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harford Memorial Gardens 2/21 | | 20c. LOCATION — City or Town, State
Aberdeen, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Mitchell-Smith Funeral Home, P.A.
Havre de Grace, MD 21078-3197 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Metastatic Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 MD | | | | 29c. LICENSE NUMBER
D33551 | | 29d. DATE SIGNED (Month, Day, Year)
2/20/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MICHAEL AUERBACH 9000 FRANKLIN SQ N 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 21 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06878

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Robert J. Anderson Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 1 1995 | | 3. TIME OF DEATH
10:45 P. M. | |
| 4. SOCIAL SECURITY NUMBER
228 46 28 13 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
56 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan 22, 1939 | |
| 9a. FACILITY NAME (If not institution, give street and number)
540 Brightwood Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Millersville | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Millersville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
540 Brightwood Road | | | | 10f. ZIP CODE
21108 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Serviceman | | 16b. KIND OF BUSINESS/INDUSTRY
Marine Corps | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Carl Montague Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marion Gray | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mitzi Anderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
540 Brightwood Road Millersville, Maryland 21108 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Carmel Cemetery | | DATE
3/4 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Cardiopulmonary Failure</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <u>Spinal Cord Tumor, Malignant</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
PA MD043057L | | 29d. DATE SIGNED (Month, Day, Year)
2 March 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard G. Ellenbogen M.D. Neurosurgery Service Washington, D.C. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06879

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LILLIAN ADELE ALLEWALT | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 24 YEAR 1995 | | | | 3. TIME OF DEATH
4:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
213-52-7215 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 9a. FACILITY NAME (If not institution, give street and number)
LORIEN RIVERSIDE NURSING AND REHAB. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
RIVERSIDE | | | | 9c. COUNTY OF DEATH
HARFORD | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
TOWSON | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1719 RED OAK ROAD | | | | 10f. ZIP CODE
21234 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8th GRADE College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
WALTER DELBERT BROOKS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
IRENE CHENOWETH | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DEANNA WINDSOR | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2501 OLD JOPPA RD. JOPPATOWNE, MD 21085 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GARDENS OF FAITH | | DATE
3/1/95 | | 20c. LOCATION — City or Town, State
PARKVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Christina A. Kopyeff</i> | | | | 22. NAME AND ADDRESS OF FACILITY
JOHNSON FUNERAL HOME
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Obstructive Dancer

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | | | | | | | Approximate Interval Between Onset and Death
3 months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John F. ...</i> | | | | 29c. LICENSE NUMBER
D28339 | | 29d. DATE SIGNED (Month, Day, Year)
March 1, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LINDA FREUCHT 101 E Wheel Road Bel Air 21015 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06880

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
VIRGINIA D. ALFORD | | | | 2. DATE OF DEATH
MONTH 3 DAY 1 YEAR 1995 | | 3. TIME OF DEATH
8A.M. M | |
| 4. SOCIAL SECURITY NUMBER
216-32-1699 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
2/27/1932 | |
| 8a. FACILITY NAME (If not institution, give street and number)
836 WOODWARD STREET | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 8c. COUNTY OF DEATH
BALTO. CITY | |
| 9a. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION
BALTIMORE | | 9c. COUNTY OF DEATH
BALTO. CITY | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTO. CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
836 WOODWARD STREET | | | | 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
AFR. AMERICAN | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MAID | | 16b. KIND OF BUSINESS/INDUSTRY
HOTEL | | | |
| 17. FATHER'S NAME (First, Middle, Last)
FURMAN ANDERSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BESSIE ANDERSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JAMES SCOTT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
834 WOODWARD STREET, BALTIMORE, MARYLAND 21230 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT ZION CEMETERY 3/6/95 | | DATE | | 20c. LOCATION — City or Town, State
LANSDOWN, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ESTEP BROTHERS FUNERAL HOME, P.A.
1300 EUTAW PLACE, BALTIMORE, MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebro Vascular Accident</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <i>Hypertension</i>
c. <i>ISCVD</i>
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes mellitus, Hypertension, COPD</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Benjamin Bandong MD</i> | | | | 29c. LICENSE NUMBER
D16938 | | 29d. DATE SIGNED (Month, Day, Year)
3-3-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BENJAMIN BANDONG MD 1201 W. SANDOGA ST. BALTO. MD 21223 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANTHONY A. BROOKS, JR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 27, 1995 | | 3. TIME OF DEATH
17:41 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
215-86-3451 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
19 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Mar. 11, 1975 Maryland | | | | | | | |
| 9a. FACILITY NAME (If not Institution, give street and number)
SINAI HOSPITAL ER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
N/A | | | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | | | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 10e. STREET AND NUMBER
4124 Fairfax Road | | | | 10f. ZIP CODE
21216 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th grade
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Painter | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Anthony A. Brooks, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LaReviao Julian | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LaRosezo Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4124 Fairfax Road Baltimore, Maryland 21216 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest Vet. Cem. 3/8/95 | | 20c. LOCATION — City or Town, State
Owings Mills, Md. | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Henry Harris</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Chatman-Harris F/H Baltimore, Md 21215 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gunshot of Chest</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicida 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Henry Harris</i>
OCME | | 29c. LICENSE NUMBER
OCME | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 28, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Sarah A. Boyle</u> | | | | 2. DATE OF DEATH
MONTH <u>3</u> DAY <u>4</u> YEAR <u>95</u> | | | | 3. TIME OF DEATH
<u>1045A</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>213-16-3830</u> | | 5. SEX
<u>1</u> <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (in yrs. last birthday)
<u>87</u> YRS. | 7. DATE OF BIRTH (Month, Day, Year)
<u>3/18/07</u> | | 8. BIRTHPLACE (State or Foreign Country)
<u>MD</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>John Hopkins Bay View Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Baltimore City</u> | | | | 9c. COUNTY OF DEATH
<u>MD</u> | |
| 10a. STATE
<u>MD</u> | | | | 10b. COUNTY
<u>Baltimore City</u> | | 10c. CITY, TOWN OR LOCATION
<u>Baltimore City</u> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>3406 Esther Place</u> | | | | 10f. ZIP CODE
<u>21224</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>White</u> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<u>Unk.</u> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Nurse</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Health Care</u> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>William Boyle</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Alice Magraw</u> | | | | | |
| 19a. INFORMANT'S NAME (Type Print)
<u>Leo Boyle</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>332 E. Main St. Emmitsburg, MD 21727</u> | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Emmitsburg Memorial Cem. 3/7</u> | | 20c. LOCATION — City or Town, State
<u>Emmitsburg, MD</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Howard P. Zahabaly</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>B. Dabrowski & Son Funeral Home
2818 E. Baltimore St. Baltimore, MD 21224</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u>
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<u>Pneumonia</u>
Due to (or as a consequence of):
<u>Myocardial Infarction</u> | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Myocardial Infarction</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Howard P. Zahabaly MD</u> | | | | | | 29c. LICENSE NUMBER
<u>95017</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>3/4/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR 07 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Andrew Rankin</u> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06883

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lawrence W. Barber | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 1 1995 | | 3. TIME OF DEATH
11:40 P.M. | |
| 4. SOCIAL SECURITY NUMBER
081-05-0578 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 8, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number)
510 Drury Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
510 Drury Lane | | | | 10f. ZIP CODE
21229 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Consultant | | 16b. KIND OF BUSINESS/INDUSTRY
Investment | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Jeffrey Barber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gertrude Borden | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anne Barber (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
510 Drury Lane Baltimore, Maryland 21229 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
New Cathedral Cemetery March 6, 1995 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>R. Clay Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Leroy M & Russell C Witzke Funeral Homes
1630 Edmondson Avenue Catonsville Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death
5 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>J. William Cook</i> | | | | 29c. LICENSE NUMBER
D-44243 | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. William Cook - 516 N. Rolling Rd Beto. MD 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


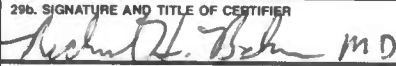

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed within 24 hours after death, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06884

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
STR. MATILDA BIEVENOUR | | | | 2. DATE OF DEATH
MONTH MARCH DAY 2 YEAR 95 | | 3. TIME OF DEATH
2357 M | |
| 4. SOCIAL SECURITY NUMBER
578-66-5165 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 2, 1897 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number)
St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
N/A | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3813 Edmondson Avenue Holy Cross Place | | | |
| 10f. ZIP CODE
21229 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Education | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Anthony Bievenour | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bertha Loyd | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sister Camilla Fitzgerald | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2024 Georgian Woods Place Wheaton, Maryland 20902 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gates Of Heaven Cemetery 03-08-95 | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Leroy M & Russell C Witzke Funeral Homes
1630 Edmondson Avenue Catonsville, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Urinary Tract Infection
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
3 days | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | 10 years | |
| | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Osteoporosis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
MD44404 | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard H. Baker ST Agnes Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1500000

Item 9a, g-721, 3-1-95, perf. h., dr
 FOR
 STATE
 REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Beasley Sr. | | | | 2. DATE OF DEATH
MONTH Feb. DAY 25 YEAR 1995 | | 3. TIME OF DEATH
1:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER
578-14-3588 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
March 7, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country)
VA | | | | 9a. FACILITY NAME (If not institution, give street and number)
2700 N. CHARLES ST. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto | |
| 9c. COUNTY OF DEATH
Balto | | | | 10a. STATE
md | | 10b. COUNTY
Balto | |
| 10c. CITY, TOWN OR LOCATION
Balto | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
2106 Braddish Ave | |
| 10f. ZIP CODE
21216 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (1-12) Unknown College (14 or 5+) unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
unknown | | 16b. KIND OF BUSINESS/INDUSTRY
Bethlehem steel | |
| 17. FATHER'S NAME (First, Middle, Last)
Ernest Dangerfield | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Flossie Beasley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Geraldine Beasley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2106 Braddish Ave Balto, md 21216 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
King Memorial Plk 3/2/95 | | 20c. LOCATION — City or Town, State
Randallstown, md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Portia Chron | |
| 22. NAME AND ADDRESS OF FACILITY
March A H West 4300 Wabash Ave | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Meningitis

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Infected ventricular shunt

a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D27034 | | 29d. DATE SIGNED (Month, Day, Year)
Feb 25 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Tracy H. Corbett, MD, 5310 Old Court Road Suite 201 Randallstown MD 21133 | | | | | | | |
| 31. DATE FILED
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

BALTIMORE, MARYLAND 21215-0020
 DIVISION OF VITAL RECORDS, P.O. BOX 68760
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06886

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Barabas, Ida</i> | | | | 2. DATE OF DEATH
MONTH <i>3</i> DAY <i>1</i> YEAR <i>95</i> | | | | 3. TIME OF DEATH
<i>2:58 PM</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>212-14-9777</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>77</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>4/17/17</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Balto, Md.</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Morden N.H.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>1801 Westworth Rd. Balto, Md.</i> | |
| 9c. COUNTY OF DEATH
<i>Balto Co</i> | | | | 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>na</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>5009 Catalpha Road</i> | |
| 10f. ZIP CODE
<i>21214</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<i>No</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>Grammar</i> College (14 or 5+) <i>na</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Homemaker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Samuel Shapiro</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Dora Klein</i> | | | | 19a. INFORMANT'S NAME (Type/Print)
<i>Mr Edward Barabas</i> | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5009 Catalpha Rd, Baltimore, MD 21214</i> | | | | 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>State Anatomy Board
655W. Baltimore St, Balto, MD 21201</i> | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ischemic Cardiomyopathy</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. <i>Advanced Atherosclerosis</i>
b. <i>Cardiovascular disease</i>
c. <i>Cardiovascular disease</i>
d. <i>Cardiovascular disease</i> | | | | Approximate Interval Between Onset and Death
<i>months</i>
<i>years</i> | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes Mellitus</i>
<i>Renal Failure</i> | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William L. ...</i> | | | | 29c. LICENSE NUMBER
<i>708358</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>3/1/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>GRACIE V. PATRICIO</i> | | | | 31. DATE FILED (Month, Day, Year)
<i>MAR - 6 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>...</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06887

Item# 1. G-film 721 PER F.H 3/6/95 P.C


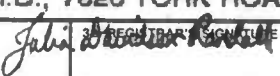
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CECILIA DUKE COMBS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Mar 5 1995 | | 3. TIME OF DEATH
7:50 pm M | |
| 4. SOCIAL SECURITY NUMBER
213-34-0698 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 1, 1910 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Saint Joseph Medical Center | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Towson, Maryland | | 8c. COUNTY OF DEATH
Baltimore | |
| 9a. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Glen Arm | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11630 Glen Arm Rd. | | | | 10f. ZIP CODE
21057 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Data Processor | | 16b. KIND OF BUSINESS/INDUSTRY
Maryland Department of Highway's | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Thomas Duke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Stuart Hayden | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Elizabeth C. Carver | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1609 La Salle Rd. Forest Hill, Md. 21050 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Loudon Park Cemetery 3/9/95 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST (RESUSCITATED)

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MYOCARDIAL INFARCTION
c.
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES HYPERTENSION
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | Approximate Interval Between Onset and Death
3 DAYS |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
D37254 | | 29d. DATE SIGNED (Month, Day, Year)
3/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BOON P. LIM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995
 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The new record of death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, the medical examiner must be notified at once.

95 06888

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Raymond Steven Costantino | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 3 1995 | | 3. TIME OF DEATH
2109 M | |
| 4. SOCIAL SECURITY NUMBER
204-34-6469 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 29, 1944 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Washington County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hagerstown | | 9c. COUNTY OF DEATH
Washington | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Columbia | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6298 Setting Star | | | | 10f. ZIP CODE
21045 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher/Counselor | | 16b. KIND OF BUSINESS/INDUSTRY
High School | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Cenzio Costantino | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Amelia Petrarca | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Patricia Costantino (spouse) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6298 Setting Star Columbia, Maryland 21045 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Columbia Memorial Park March 7, 1995 | | 20c. LOCATION — City or Town, State
Clarksville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leroy M. Russell</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Leroy M & Russell C Witzke Funeral Homes
5555 Twin Knolls Road Columbia, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Coronary occlusion</i> Sudden | | | | | | | |
| b. <i>Atherosclerotic cardiovascular disease</i> yrs | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>L. H. Weeks</i> | | | | 29c. LICENSE NUMBER
D11266 | | 29d. DATE SIGNED (Month, Day, Year)
Mar 4 95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
H.N. Weeks 580 Northern Av Hagerstown MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06889

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Henry Dease Jr. | | | | 2. DATE OF DEATH
MONTH March DAY 3 YEAR 1995 | | 3. TIME OF DEATH
3.20 A M | |
| 4. SOCIAL SECURITY NUMBER
247-66-5596 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
53 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
11-21-41 | |
| 8. FACILITY NAME (If not institution, give street and number)
4410 Old Frederick Rd | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto | | 9c. COUNTY OF DEATH
NA | |
| 10a. STATE
Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4410 Old Frederick Rd Apt-A | | 10f. ZIP CODE
21229 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (13 or 5+) N/A | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Self-Employed | | | | 16b. KIND OF BUSINESS/INDUSTRY
Transport Service | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Dease Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Regina Alston | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary F. Dease | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4410 Old Frederick Rd Apt A Baltimore, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Paul A.M.E. Church | | 20c. LOCATION — City or Town, State
Plantersville, S.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Portia Ebron | | | | 22. NAME AND ADDRESS OF FACILITY
Maugh F. H. West
4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTRIC CANCER

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D29071 | | 29d. DATE SIGNED (Month, Day, Year)
3.3.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R-KRISHNAN, MD #21 N.E. 7th St. #205 BALTIMORE 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06890

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Marie F. Dombay | | | | 2. DATE OF DEATH
MONTH DAY YEAR
2 28 95 | | 3. TIME OF DEATH
2:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER
177-10-5069 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12/7/1918 | |
| 9a. FACILITY NAME (If not institution, give street and number)
7867 Kings Bench Place | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Pasadena | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Pasadena | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7867 Kings Bench Place | | | | 10f. ZIP CODE
21122 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)
Sales Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Department Store | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Francis (Frank) Kennedy | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Dooling | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Betty Sullivan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7867 Kings Bench Pl. Pasadena, MD 21122 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holy Cross | | DATE
3/4 | | 20c. LOCATION - City or Town, State
Yeadon, Pennsylvania | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic kidney cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY - At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
027938 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Angele Gonce 795 Aqueduct Rd. Glen Burnie MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06891

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Michael George Doughman | | | | 2. DATE OF DEATH
MONTH March DAY 3, 1995 YEAR 1995 | | 3. TIME OF DEATH
12:55 P M | |
| 4. SOCIAL SECURITY NUMBER
298-56-0543 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 14, 1956 | |
| 9a. FACILITY NAME (If not institution, give street and number)
9 Running Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Essex | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Essex | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9 Running Court | | | | 10f. ZIP CODE
21221 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1977-1985 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sales | | 16b. KIND OF BUSINESS/INDUSTRY
Computer | |
| 17. FATHER'S NAME (First, Middle, Last)
George W. Doughman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Corrinne E. Mazza | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Janice B. Doughman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Running Ct. Baltimore, MD. 21221 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MD Vet. Cemetery 3/7/95 | | 20c. LOCATION — City or Town, State
Garrison Forest Baltimore Co. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John Brudzinski</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Brudzinski Funeral Home P.A. 21221
1407 Old Eastern Ave. Baltimore MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Cerebrovascular</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <i>Liver Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. <i>Kidney Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
N/A | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
N/A | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Anna Mae Diehl MD</i> | | | | 29c. LICENSE NUMBER
D31079 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Anna Mae Diehl, 912 Ross Bld, Johns Hopkins Univ.</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Brudzinski</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06892

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
EDITH DELZANGLE | | | | 2. DATE OF DEATH
MONTH 3 DAY 4 YEAR 95 | | 3. TIME OF DEATH
6:10 P M | |
| 4. SOCIAL SECURITY NUMBER
220-01-5442 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-21-1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Johns Hopkins Bayview M. C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Edgemere | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2400 S. Snyder Ave. | | | | 10f. ZIP CODE
21219 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 15b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Hicks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edna Bagley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Phyllis Schroeder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2400 S. Snyder Ave. Baltimore, Md. 21219 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gardens of Faith Cem. 3-8 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Anthony Colt Connelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Connelly Funeral Home of Dundalk
7110 Sollers Point Rd. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. coma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
anemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Steven Kravet</i> Physician | | | | 29c. LICENSE NUMBER
MD44969 | | 29d. DATE SIGNED (Month, Day, Year)
3/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
STEVEN KRAVET 4940 EASTERN AVE, BALTIMORE, MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06893

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANNA EVANS ANNA EVANS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 1 1995 | | 3. TIME OF DEATH
7:43 P.M. | |
| 4. SOCIAL SECURITY NUMBER
213 09 1519 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (in yrs. last birthday)
84 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
7-13-1910 | | 8. BIRTHPLACE (State or Foreign Country)
West Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
na | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3701 Mohawk Avenue | | | |
| 10f. ZIP CODE
21229 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY
Laundry/Food/Clothing | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Chester Isner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Angelina | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert Henry | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 S. Augusta Ave, Balto, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <i>Septicemia</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Cellulitis of the Left Leg</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>COLON CARCINOMA</i>
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Joshua Imperio MD</i> | | | | 29c. LICENSE NUMBER
D45V55 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 1, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSHUA IMPERIO LIBERTY MEDICAL CENTER, BALTIMORE MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Robert Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, II, 27 PER MEO G-722 4/21/95 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROSE FRANCES FLORIO | | | | 2. DATE OF DEATH
MONTH FEB. 28, 1995 YEAR 1995 | | 3. TIME OF DEATH
16:04 P M | |
| 4. SOCIAL SECURITY NUMBER
220-35-3711 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 9, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not Institution, give street and number)
HARFORD MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
Havre de Grace | |
| 9c. COUNTY OF DEATH
HARFORD | | | | 10a. STATE
Maryland | | 10b. COUNTY
Harford | |
| 10c. CITY, TOWN OR LOCATION
Aberdeen | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
2 Aberdeen Avenue | |
| 10f. ZIP CODE
21001 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 7 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Fredrick (nm) Burcker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Virginia (nm) (unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jack Thomas Florio | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Aberdeen Avenue, Aberdeen, Md. 21001 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cokesbury Methodist Cemetery 3/3/95 Abingdon, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
OCME | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 01, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 6 1995 | | 32. REGISTRY NUMBER
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06895

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BERNARD GAENG | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Mar 1 1995 | | 3. TIME OF DEATH
M
4:54 pm | |
| 4. SOCIAL SECURITY NUMBER
213-03-6419 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9/27/18 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9. CITY, TOWN OR LOCATION OF DEATH
Towson, Maryland | | 10. COUNTY OF DEATH
Baltimore | |
| 11. FACILITY NAME (If not institution, give street and number)
Saint Joseph Medical Center | | | | | | | |
| 12. RESIDENCE OF DECEDENT | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY, TOWN OR LOCATION
TOWSON | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 14a. STREET AND NUMBER
1512 GLEN KIETH BLVD. | | | | 14b. ZIP CODE
21286 | | 14c. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 18. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 19. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A
College (1-4 or 5+) 2 YEARS | | 20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
INDUSTRIAL ENGINEER | | 21. KIND OF BUSINESS/INDUSTRY
MANUFACTURING | | | |
| 22. FATHER'S NAME (First, Middle, Last)
JOHN A GAENG | | | | 23. MOTHER'S NAME (First, Middle, Maiden Surname)
BEATRICE TYSON | | | |
| 24. INFORMANT'S NAME (Type/Print)
EDNA GAENG | | | | 25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1512 GLEN KIETH BLVD. TOWSON, MD 21286 | | | |
| 26. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MOST HOLY REDEEMER CEM. 3/6/95 | | 28. LOCATION — City or Town, State
BALTIMORE, MD | | 29. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Christina L. Kopczyk</i> | |
| 30. NAME AND ADDRESS OF FACILITY
JOHNSON FUNERAL HOME
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | 31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOGENIC SHOCK

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. ISCHEMIC HEART DISEASE
b.
c.
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY FIBROSIS, RHEUMATOID ARTHRITIS | | | | | |
| 32. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 33. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 34. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 35. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 36. 26. PLACE OF DEATH (Check only one)
<input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
<input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 37. 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 38. 28a. DATE OF INJURY (Month, Day, Year) | | 39. 28b. TIME OF INJURY
M | | 40. 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 41. 28d. DESCRIBE HOW INJURY OCCURRED | |
| 42. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 43. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 44. 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 45. 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Francis Khoo</i> | | | | 46. 29c. LICENSE NUMBER
D 30263 | | 47. 29d. DATE SIGNED (Month, Day, Year)
3-3-95 | |
| 48. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANCIS KHOO, M.D., ST. JOSEPH MEDICAL CENTER, 7620 YORK RD., TOWSON, MD. 21204 | | | | | | | |
| 49. 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 50. 32. REGISTRAR'S SIGNATURE
<i>Julia Anderson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

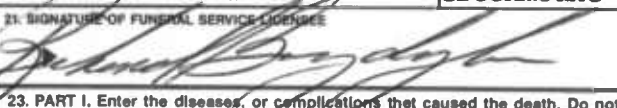
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06896

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Juanita E. Goode | | | | 2. DATE OF DEATH
MONTH March DAY 4, 1995 YEAR | | | | 3. TIME OF DEATH
about 2 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER
213-38-5419 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
7/20/42 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
2108 Mighty Acres Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Dundalk | | | | 9c. COUNTY OF DEATH
Baltimore County | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Baltimore County | | | | 10c. CITY, TOWN OR LOCATION
Dundalk | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2108 Mighty Acres Road | | | | 10f. ZIP CODE
21222 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Assistant Accountant | | | | 16b. KIND OF BUSINESS/INDUSTRY
Food Store | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Unknown | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John Goode | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2108 Mighty Acres Road Dundalk, Maryland 21222 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greenmount Crematory | | | | OATE | | 20c. LOCATION — City or Town, State
Baltimore City, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Bruzdinski Funeral Home P.A.
1407 Eastern Ave Baltimore, Maryland 21221 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Bashar Karakash, M.D. | | | | 29c. LICENSE NUMBER
P07387 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BASHAR KARAKASH 9000 Franklin Square Dr. Baltimore MD 21237 | | | | | | | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06897

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RUFUS HALLETTE GARDNER, III | | | | 2. DATE OF DEATH
MONTH March DAY 4 YEAR 1995 | | 3. TIME OF DEATH
4:45 A M | |
| 4. SOCIAL SECURITY NUMBER
461-09-6353 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 25, 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number)
100 W. University Pkwy. Apt. 5A | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
Md. | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
100 W. University Pkwy. Apt. 5A | | | | 10f. ZIP CODE
21210 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Editor | | 16b. KIND OF BUSINESS/INDUSTRY
Baltimore Sun Newspaper | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Rufus Hallette Gardner, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kathleen Moorman | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Shelley Post Gardner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 W. University Pkwy. Apt. 5A Baltimore, Md. 21210 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maplewood Cemetery 3/9/95 | | 20c. LOCATION — City or Town, State
Mayfield, Kentucky | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | ACUTE LYMPHOBLASTIC LEUKEMIA | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John A. Nesbitt, M.D. | | | | 29c. LICENSE NUMBER
014623 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John A. Nesbitt, III, M.D. 201 E. University Pkwy, Baltimore, Md. 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06898

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Clarence W. Gischel | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 3, 1995 | | 3. TIME OF DEATH
3:15 P M | |
| 4. SOCIAL SECURITY NUMBER
215-10-4951 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 5, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number)
13805 E. Devonfield Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baldwin | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baldwin | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13805 E. Devonfield Drive | | | | 10f. ZIP CODE
21013 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Trucking | | 16b. KIND OF BUSINESS/INDUSTRY
Owner | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry A. Gischel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rose E. Baldwin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Oscar N. Dale | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
289 Littleton Quarter, Williamsburg, Va. | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Moreland Memorial Park 3/06 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gary L. Kaufman | | | | 22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., Elkridge, Md. 21227 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic Prostate Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death
years. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Carcinoma of the Colon, Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Mark J. Wild, MD | | 29c. LICENSE NUMBER
d35522 | | 29d. DATE SIGNED (Month, Day, Year)
3-3-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mark J. Wild, MD 2 North Ave., Suite 101, Bel Air, MD 21014 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06899

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GORDEN D. GOLDIE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 23 1995 | | 3. TIME OF DEATH
4:40 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-25-29 | |
| 9a. FACILITY NAME (If not institution, give street and number)
1313 OLD EASTERN AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Baltimore Co | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1313 Old Eastern Avenue | | | |
| 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis of the liver
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic alcoholism
Arteriosclerotic cardiovascular disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Donald G Wright MD | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 24, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Donald G Wright MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0871-510

95-59

95 06900

blh

ITEMS: 4.6.10d, 10e -22, PER F.H./23 PART I, 27, 28a-f, PER MEO FILM G-721

1. FOR
STATE 3/17/95 t.t.
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
WANDA L. GARRETT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 18 1995 | | 3. TIME OF DEATH
M
0537 | |
| 4. SOCIAL SECURITY NUMBER
213-80-0664 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
30 -31 yrs. | | 7. DATE OF BIRTH (Month, Day, Year)
10-22-64 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Johns Hopkins Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
Maryland | | 10b. COUNTY
na | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
633 Pratt Street (West) | | | | 10f. ZIP CODE
21201 21222 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4 or 5+) UNEMPLOYED | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM J. GARRETT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
JANICE GREEN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JANICE GROSS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
80 RUMELIA CIRCLE BALTIMORE, MD. 21221 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. ZION CEMETERY 13/18 | | 20c. LOCATION — City or Town, State
LANSLOWNE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Donald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board 6550 Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. COCAINE AND ALCOHOL INTOXICATION WITH COMPLICATIONS
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
FOUND 2-15-95 | | 28b. TIME OF INJURY
UNKNOWN M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
UNKNOWN | | 28d. DESCRIBE HOW INJURY OCCURRED
UNKNOWN | | | |
| 29a. CERTIFIER (Check only)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
Feb 18 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John A. Ron Cooke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | 32. REGISTRAR'S SIGNATURE
John A. Ron Cooke | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RAYMOND JOHN HAWKINS Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 26 95 | | 3. TIME OF DEATH
9:34 PM | |
| 4. SOCIAL SECURITY NUMBER
214 40 0111 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 16, 1942 | |
| 9a. FACILITY NAME (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
===== | |
| 10a. STATE
Maryland | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Elkridge | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6636 Washington Blvd. #93 | | | | 10f. ZIP CODE
21227 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Hydro Tank Tester | | 16b. KIND OF BUSINESS/INDUSTRY
Bethlehen Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Joseph Hawkins Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Vernita May Schaefer | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anita Hawkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6636 Washington Blvd. #93 Elkridge, Maryland 21227 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glen Haven Memorial Park 3/4 | | 20c. LOCATION — City or Town, State
Glen Burnie, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Donna M. Zmijewski</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donna M. Zmijewski</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
FEB 27, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RAYMOND A. HAWKINS JR 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Donna M. Zmijewski</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06902

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
ANNA C. HASPERT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 3, 1995 | | 3. TIME OF DEATH
1:35 A M | |
| 4. SOCIAL SECURITY NUMBER
a 215-03-3879 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
MARCH 21, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country)
RUSSIA | | | | 9a. FACILITY NAME (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL ASSOCIATION | | 9b. CITY, TOWN OR LOCATION OF DEATH
GLEN BURNIE | |
| 9c. COUNTY OF DEATH
A.A. COUNTY | | | | 10a. STATE
MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1430 RICHARDSON STREET | |
| 10f. ZIP CODE
21230 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 10TH College (1-4 or 5+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
ANALYST | | 16b. KIND OF BUSINESS/INDUSTRY
SOCIAL SECURITY | |
| 17. FATHER'S NAME (First, Middle, Last)
PETER P. HASPERT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MAGDALANE RYANBACKER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
PETER HASPERT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
134 CLUB ROAD PASADENA, MARYLAND, 21122 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HOLY CROSS CEMETERY, MARCH 6, 1995 MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Victor P. Dade Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
CHARLES L. STEVENS FUNERAL HOME, INC.
1501 E. FORT AVENUE, BALTIMORE, MARYLAND 21230 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <i>Myocardial Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Recent stroke</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>J. Presbitero, MD</i> | | | | 29c. LICENSE NUMBER
D16208 | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSE M. PRESBITERO, M.D./7845 OAKWOOD RD #100/GLEN BURNIE, MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Dawson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06903

Item # 18 Film # 6 721 3-7-95 N.A., Per Funeral Home

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BARTOLOMEJ | | | | 2. DATE OF DEATH
MONTH FEBRUARY DAY 27 YEAR 1985 | | | | 3. TIME OF DEATH
3:55 AM | |
| 4. SOCIAL SECURITY NUMBER
131 44 3386 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sep 30 1908 | | 8. BIRTHPLACE (State or Foreign Country)
Czechoslovakia | |
| 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Rockville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
10 Valerian Court | | | | 10f. ZIP CODE
20852 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Financial Analyst | | | | 16b. KIND OF BUSINESS/INDUSTRY
Swiss Bank | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Adolf Grunberger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Serena Gluck-Gottlieb | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Katarina Avnet | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as item 10 a-f | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
New Montifore Cemetery 3/5 Long Island, N.Y. | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Ives-Pearson Funeral Homes
2847 Wilson Blvd Arlington, VA 22201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia, Bilateral
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate interval Between Onset and Death
2 1/2 weeks | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Serena Gluck-Gottlieb, Chronic obstructive pulmonary disease
Coronary artery disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Sidney J. Cohen, M.D. Physician</i> | | | | 29c. LICENSE NUMBER
DO 1173 | | 29d. DATE SIGNED (Month, Day, Year)
2-28-85 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Sidney J. Cohen, MD 121 Congressional Lane, Rockville, MD 20852 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1985 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO



THE UNIVERSITY OF CHICAGO

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>David E. Hoesch</u> David Eugene Hoesch, Jr. | | | | 2. DATE OF DEATH
MONTH <u>03</u> DAY <u>01</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>0521 4</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>217-80-6408</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>33</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>8/17/61</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>MARYLAND</u> | | | | 9. COUNTY OF DEATH
<u>N/A</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>UNIVERSITY HOSPITAL</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>BALTIMORE CITY</u> | | 9c. COUNTY OF DEATH
<u>N/A</u> | |
| 10a. STATE
<u>MARYLAND</u> | | | | 10b. COUNTY
<u>BALTIMORE</u> | | 10c. CITY, TOWN OR LOCATION
<u>COCKEYSVILLE,</u> | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>500 PADIEN LANE</u> | | 10f. ZIP CODE
<u>21030</u> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>WHITE</u> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u> <u>College (1-4 or 5+)</u>
<u>12th GRADE</u> <u>N/A</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>CHEF</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>RESTAURANT</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>DAVID E. HOESCH, SR.</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>THERESE MILANI</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>DAVID E. HOESCH, SR.</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3306 SUMMIT AVENUE BALTIMORE, MD 21234</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>METRO CREMATORY, INC. 3/3/95 CATONSVILLE, MD</u> | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Christina L. Kopecky</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>JOHNSON FUNERAL HOME</u>
<u>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <u>Sepsis</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <u>Soft tissue infection</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u>motor vehicle accident</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ | | | | | | | |
| 24. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year)
<u>02/14/95</u> | | | | | | | |
| 28b. TIME OF INJURY
<u>0100A M</u> | | | | | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURED
<u>motor vehicle accident</u> | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
<u>roadway</u> | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
<u>Padenia Road Baltimore County Maryland</u> | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature]</u> | | | | | | | |
| 29c. LICENSE NUMBER
<u>[Signature]</u> | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year)
<u>03/01/95</u> | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Elizabeth Dreesen MD 225 Greene St Baltimore</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR 07 1995</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



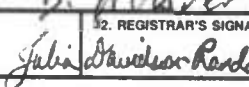
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06905

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Don Rex Henry | | | | 2. DATE OF DEATH
MONTH 3 DAY 3 YEAR 95 | | 3. TIME OF DEATH
2:45 A M | |
| 4. SOCIAL SECURITY NUMBER
215-03-9610 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11/8/01 | |
| 9a. FACILITY NAME (If not institution, give street and number)
EDENWALD NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
RODGERS FORGE | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10e. STREET AND NUMBER
51 DUNKIRK ROAD | | | | 10f. ZIP CODE
21212 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
3 Widowed 4 Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?
1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY
AT&T TECHNOLOGIES | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM WARREN HENRY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
RUTH DRENNAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
SALLY MURRAY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
51 DUNKIRK ROAD RODGERS FORGE, MD 21212 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METRO CREMATORY, INC. 3/3/95 | | 20c. LOCATION — City or Town, State
CATONSVILLE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Severe end-stage emphysema
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
10 yrs | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Chronic obstructive disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | c. 10 yrs | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFY (check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
029769 | | 29d. DATE SIGNED (Month/Day/Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Monica S. Alvarez 516 N. Golby Rd Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06906

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Leon Hall</i> | | 2. DATE OF DEATH
MONTH <i>3</i> DAY <i>2</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>0040</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>217-24-6905</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>64</i> YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
<i>5-8-30</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>MD</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>UNIVERSITY HOSPITAL</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>BALTO.</i> | | 9c. COUNTY OF DEATH
<i>BALTO. CITY</i> | |
| 10a. STATE
<i>MD</i> | | 10b. COUNTY
<i>A.A. CO.</i> | | 10c. CITY, TOWN OR LOCATION
<i>PASADENA</i> | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>4045 BRUMMEL RD.</i> | | 10f. ZIP CODE
<i>21122</i> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify | | 14. RACE — American Indian, Black, White, etc.
Specify <i>BLK.</i> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i>
<i>12</i> | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>HANDYMAN</i> | | 16. KIND OF BUSINESS/INDUSTRY
<i>UNKNOWN</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>LEONARD HALL</i> | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>GERTRUDE HALL</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>JANE MELVIN</i> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>6668 SHELLY RD GLEN BURNIE MD 21061</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
<i>MT. ZION CEM. (CHURCH)</i> | | 20c. DATE
<i>3/7/95</i> | |
| 20d. LOCATION — City or Town, State
<i>PASADENA MD</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<i>ESTEP BROTHERS FUNERAL HOME P.A.</i> | | 22. ADDRESS OF FACILITY
<i>1300 EUTAW PLACE BALTO. MD 21217</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intracerebral Hemorrhage</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <i>Hypertension</i>
c.
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Alcoholic Hepatitis</i> | | | | | Approximate Interval Between Onset and Death
<i>7 Days</i>
<i>Years</i> |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature] Resident</i> | | 29c. LICENSE NUMBER
<i>6614</i> | |
| 29d. DATE SIGNED (Month, Day, Year)
<i>3/2/95</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>P Doherty 22 S Greene St Balto MD 21201</i> | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 06 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06907

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
EDWARD O. HUNT SR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 02 95 | | 3. TIME OF DEATH
0820 M | |
| 4. SOCIAL SECURITY NUMBER
239-14-4265 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09 09 05 | |
| 9a. FACILITY NAME (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTO. CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTO. CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
269 S. HILTON ST. | | | | 10f. ZIP CODE
21229 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MINISTER | | 16b. KIND OF BUSINESS/INDUSTRY
CHURCH MINISTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
BASIL GOLDRING | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HATTIE H. SKINNER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
EDWARD O. HUNT JR. M.D. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1190 W. NORTHERN PKWY. BALTO. MD 21210 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
ARBUTUS MEM. PARK 3/7/95 | | 20c. LOCATION — City or Town, State
ARBUTUS MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multisystem Failure
DUE TO (OR AS A CONSEQUENCE OF):

b. Incarcerated Bowel
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
1884 | | 29d. DATE SIGNED (Month, Day, Year)
March 2, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMN-16 Rev 1/89

95 06909

Items 9a, 10e, & 15, g-721, 3-8-95, per f.h., dr

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>MARY HOWARD</i> | | | | 2. DATE OF DEATH
MONTH <i>Feb.</i> DAY <i>28</i> YEAR <i>1995</i> | | | | 3. TIME OF DEATH
<i>12 Noon</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER
<i>257-14-5231</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Feb. 26, 1911</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Georgia</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>5519 Nome Ave.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | | | 9c. COUNTY OF DEATH
<i>N/A</i> | | | | | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>N/A</i> | | | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>5519 Nome Ave.</i> | | | | 10f. ZIP CODE
<i>21215</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary <i>10</i> Secondary (10-12) <i>12</i> College (1-4 or 5+) <i>0 1</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Beautician</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Self employed</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>William Ferguson</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Ada Dailey</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Ida Wilton</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>357 Harlem Ave., Pasadena, Md.</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Arbutus</i> | | | | 20c. LOCATION — City or Town, State
<i>Balto. Co., Md.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph L. Russ</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>a. Squamous cell carcinoma of the esophagus</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>(Infiltrating moderately to poorly differentiated)</i>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
<i>c.</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>d.</i> | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Anemia</i> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>D. Roggen</i> | | | | | | 29c. LICENSE NUMBER
<i>D 35844</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>March 02, 1995</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>D. Roggen 19 Walker Ave Baltimore MD 21208</i> | | | | | | | | | | | | | |
| 31. DATE FILED
<i>MAR 08 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>J. A. ...</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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98

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
KEVIN L. JONES | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 02 1995 | | 3. TIME OF DEATH
4:22 AM | |
| 4. SOCIAL SECURITY NUMBER
216-94-1681 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
31-30 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb 7, 1964 | |
| 8. BIRTHPLACE (State or Foreign Country)
Md | | | | 9. COUNTRY OF DEATH
N/A | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
3912 HAYWARD AVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTRY OF DEATH
N/A | |
| 10a. STATE
Md | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Balto | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
3912 Hayward Avenue | | | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
U S A | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles F. Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ella Mae Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ella Mae Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3912 Hayward Avenue Balto, Md 21215 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt Zion Cemetery | | DATE
#3695 | | 20c. LOCATION — City or Town, State
Lansdown, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Stephen B. Scott</i> | | | | 22. NAME AND ADDRESS OF FACILITY
March F/H West
4300 Wabash Avenue Balto, Md 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cirrhosis of the liver</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
<i>partial</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David R. Fowler</i> | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 02, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R. Fowler 111 N. PENN ST. BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06911

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANGELA JAMES | | | | 2. DATE OF DEATH
MONTH 2 / DAY 28 / YEAR 95 | | 3. TIME OF DEATH
10:32 P.M. | |
| 4. SOCIAL SECURITY NUMBER
219-84-7527 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
29 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
7-26-1965 | |
| 8a. FACILITY NAME (If not institution, give street and number)
CHURCH HOME HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
BALTO. | | 8c. COUNTY OF DEATH
BALTO. CITY | |
| 9. RESIDENCE OF DECEDENT | | | | 10a. STATE
MD | | 10b. COUNTY
BALTO. CITY | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
34 S. EXETER ST. | |
| 10f. ZIP CODE
21202 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLK. | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHNNIE JAMES JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LORINE HARRIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LORINE HARRIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
34 S EXETER ST BALTO. MD 21202 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)
WESTERN STAR CEM. 3/4/95 | | 20c. LOCATION — City or Town, State
CATONSVILLE MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Eugene M. Hall</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypotension, Shock
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Hepatic Failure
Chronic Alcoholism | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Bohani m2</i> | | | | 29c. LICENSE NUMBER
D-26594 | | 29d. DATE SIGNED (Month, Day, Year)
8/28/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
100 N. Broadway Baltimore, MD 21231 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Juli Shuster-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06912

95-0870-510

 1 - blh
 FOR
 STATE
 REGISTRAR

ITEMS: 23 PART I, 27, 28a-f, PER MEG FILM G-721 3/30/95 t.t

 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Barry Jones | | | | 2. DATE OF DEATH
MONTH Feb DAY 18 YEAR 1995 | | 3. TIME OF DEATH
0220 M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
54 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
1-1-41 | | 8. BIRTHPLACE (State or Foreign Country) | |
| 9a. FACILITY NAME (If not institution, give street and number)
Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
na | |
| 10a. STATE
Maryland | | 10b. COUNTY
na | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
718 Newington Avenue | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
OCME | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

a. NARCOTIC INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
UNKNOWN | | 28b. TIME OF INJURY
UNKNOWN | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
UNKNOWN | | 28d. DESCRIBE HOW INJURY OCCURRED
SUBJECT INGESTED DRUGS | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
UNKNOWN | | 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
OCME | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
Feb 18 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARY F. GORE JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06913

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles Richard James Jr. | | | | 2. DATE OF DEATH
MONTH February DAY 27 YEAR 95 | | 3. TIME OF DEATH
5:10 P M | |
| 4. SOCIAL SECURITY NUMBER
217 09 5824 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-7-1912 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot County | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Queen Anne Co | | 10c. CITY, TOWN OR LOCATION
Grasonville | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1022 Chester River Drive | | | |
| 10f. ZIP CODE
21638 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Richard James, Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie Earp | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Ethel James | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21638
1022 Chester River Drive, Grasonville, MD | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655 W. Baltimore St, Balto MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
b. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. OBSTRUCTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
22 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY VASCULAR INSUFFICIENCY | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
E.F. Ciganek MD | | | | 29c. LICENSE NUMBER
D3504 B | | 29d. DATE SIGNED (Month, Day, Year)
2/27/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
E.F. Ciganek MD, PO Box 339 Centreville Md. 21617 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06914

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
KATHRYN MARY KELLER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1995 | | | | 3. TIME OF DEATH
7:05 P. M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-14-2296 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
FEB. 8, 1916 | | 8. BIRTHPLACE (State or Foreign Country)
PENNSYLVANIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SUMMIT NURSING HOME | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CATONSVILLE | | | | 9c. COUNTY OF DEATH
BALTIMORE | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
CATONSVILLE | | | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
1211 TUGWELL DRIVE | | | | 10f. ZIP CODE
21228 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12TH GRADE
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CLERK TRANSIT DEPT | | | | 16b. KIND OF BUSINESS/INDUSTRY
A & P TEA COMPANY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
GEORG ALOYSIS KLEMMER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY ASHWORTH | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LESLIE E. KELLER | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
62 GRAY ROCK ROAD - CLINTON, N.J. 08809 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY | | | | DATE
3/6 | | 20c. LOCATION — City or Town, State
BALTIMORE | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leslie E. Keller</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE - BALTIMORE, MD 21229 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart failure</i> | | | | | | | | | | | | Yrs. | | | |
| b. <i>ASCD</i> | | | | | | | | | | | | Yrs. | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. <i>Coronary artery disease</i> | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cold</i> | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND LICENSE NUMBER OF CERTIFIER
<i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER
D 36942 | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. BIPIN TURAKHIA - 1009 FREDERICK ROAD - CATONSVILLE, MARYLAND 21228 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. [Signature]</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06915

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
JULIUS J. KOUNESKI | | | | 2. DATE OF DEATH
MONTH MARCH DAY 2 YEAR 1995 | | 3. TIME OF DEATH
5:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
213-09-5910 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
80 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7. DATE OF BIRTH (Month, Day, Year)
JAN. 9, 1915 | | | | 8. BIRTHPLACE (State or Foreign Country)
BALTIMORE, MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
HARBOUR HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
13434 GLYNDON AVENUE | | | | 10f. ZIP CODE
21223 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9TH GRADE
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TAILOR | | 16b. KIND OF BUSINESS/INDUSTRY
LEBOW BROTHERS | | | |
| 17. FATHER'S NAME (First, Middle, Last)
DOMONIC KOUNESKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
VERONICA RAZGAITIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. CHARLES J. KOUNESKI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1342 GLYNDON AVENUE - BALTIMORE, MD 21223 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
LOU DON PARK CEMETERY | | DATE
3/4 | | 20c. LOCATION — City or Town, State
BALTIMORE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James E. Kling</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE—BALTIMORE, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> HYPERTENSIVE CORONARY ARTERY DISEASE </div> <div style="width: 35%;"> Approximate Interval Between Onset and Death
2 YEARS

10 YEARS </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thab An. Wahba</i> , HOUSE OFFICER | | | | 29c. LICENSE NUMBER
AS 2441614-26 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 2, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Thab Wahba 3001 S. Hanover Street Balto. Md 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Shuster-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1225-510
DWG

95 06916

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/15/95 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MICHAEL J. LUSBY | | | | 2. DATE OF DEATH
MONTH MARCH DAY 04 YEAR 95 | | 3. TIME OF DEATH
2:38A M | |
| 4. SOCIAL SECURITY NUMBER
220 70 0811 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 25, 59 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
1117 PINEHEIGHTS AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | |
| 9c. COUNTY OF DEATH
NA | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
NA | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1117 Pine Heights Avenue | | | |
| 10f. ZIP CODE
21230 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) Unemployed | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY
NA | |
| 17. FATHER'S NAME (First, Middle, Last)
Jerome M. Lusby | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen M. Lusby | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Richard W. Galloway | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
630 Sandyhill Road Severn, Maryland 21144 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gedard Hill Cemetery 3/9 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | |
| 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PHENOBARBITAL INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
FOUND: 3/4/95 | | 28b. TIME OF INJURY
FOUND: 2:30 A M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
SUBJECT INGESTED DRUG | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
FOUND: HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
1117 PINEHEIGHTS AVE. BALTIMORE CITY, MD. | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 04/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THEODORE M. KENE 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06917

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LINDA A. LANCE | | | | 2. DATE OF DEATH
MONTH 2 DAY 28 YEAR 95 | | 3. TIME OF DEATH
2012 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09 09 58 | |
| 9a. FACILITY NAME (If not institution, give street and number)
UNIVERSITY OF MD MEDICAL SYS. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE
MARYLAND | | 10b. COUNTY | | 10e. STREET AND NUMBER
521 CUMBERLAND STREET | | 10f. ZIP CODE
21217 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
NONE | | 16b. KIND OF BUSINESS/INDUSTRY
UNKNOWN | |
| 17. FATHER'S NAME (First, Middle, Last)
WENDELL LANCE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROMAINE LANCE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
WENDELL LANCE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
521 CUMBERLAND ST. BALTIMORE, MARYLAND 21217 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
KING MEMORIAL PARK 3/6 | | 20c. LOCATION — City or Town, State
WOODLAWN, MARYLAND | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles H. Brown</i> | |
| 22. NAME AND ADDRESS OF FACILITY
WILLIAM C. BROWN COMMUNITY F/H
1206 W. North Avenue | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Left Intracerebral Hematoma
DUE TO (OR AS A CONSEQUENCE OF):
b. Intraventricular Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thad</i> MD: 2/28/95 | | | | 29c. LICENSE NUMBER
A44176435 AT 2819 | | 29d. DATE SIGNED (Month, Day, Year)
2/28/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GAUTAM TITAKUR UMMC NEUROSURGERY | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06918

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARTIN A. V. LEYKO | | | | 2. DATE OF DEATH
MONTH March DAY 3 YEAR 1995 | | 3. TIME OF DEATH
1:10 P M | |
| 4. SOCIAL SECURITY NUMBER
218-05-1006 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-17-1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rosedale | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Dundalk | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2904 Cornwall Rd. | | | | 10f. ZIP CODE
21222 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Boilermaker | | 16b. KIND OF BUSINESS/INDUSTRY
Exxon | |
| 17. FATHER'S NAME (First, Middle, Last)
Martin W. Leyko | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bertha Kowalski | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rita Leyko | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2904 Cornwall Rd. Baltimore, Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Stanislaus Cem. 3-7 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Anthony Colt Connelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Connelly Funeral Home of Dundalk
7110 Sollers Point Rd. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → (D) Left Cerebral Vascular Accident

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF): Hypertension
b. DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive lung dz
c. DUE TO (OR AS A CONSEQUENCE OF): Prostate Bladder cancer
d. _____ | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Ali Sanai</i> | | | | 29c. LICENSE NUMBER
D44793 | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ali Sanai, M.D. 6730 Holabird Ave. Baltimore, Md. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John B. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06919

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ernest Louis Maggenti | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 3, 1995 | | 3. TIME OF DEATH
11:15 P. M. | |
| 4. SOCIAL SECURITY NUMBER
212-12-7632 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6-16-1914 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Meridian Nursing Center, Homewood | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Timonium | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
54 Faraday Drive | | | | 10f. ZIP CODE
21093 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9
College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sheet Metal Worker | | 15b. KIND OF BUSINESS/INDUSTRY
Martin Marietta Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Anthony Maggenti | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maria Ridolfi | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Anne Major | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same As #10 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 3-6-95 | | DATE
3-6-95 | | 20c. LOCATION — City or Town, State
Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Wallace S. Brooks, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Road, Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
2 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Richard O'Brien | | | | 29c. LICENSE NUMBER
D23076 | | 29d. DATE SIGNED (Month, Day, Year)
3-6-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard O'Brien 3730 Fall Rd 21211 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Kaskal | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06920

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RUFFES MOORE JR | | | | 2. DATE OF DEATH
MONTH DAY YEAR
03 02 95 | | 3. TIME OF DEATH
12:06 PM | |
| 4. SOCIAL SECURITY NUMBER
242-16-9530 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
03-22-1918 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
2747 BAKER STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
2747 Baker Street | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10th grade
College (1-4 or 5+) _____ | | | | 16a. DECEASED'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Company | | 16b. KIND OF BUSINESS/INDUSTRY
Cottman Oil Company | |
| 17. FATHER'S NAME (First, Middle, Last)
Ruffes Moore Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie Moore | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Oliver A. Moore | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3815 Rogers (North) Avenue Baltimore Maryland 21207 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
KING MEMORIAL PARK 3/8 | | 20c. LOCATION — City or Town, State
Woodlawn, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Barbara A. Brown</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WILLIAM C. BROWN COMMUNITY F/H
1206 W. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D29071 | | 29d. DATE SIGNED (Month, Day, Year)
3.3.95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R. KRISHNAN, MD 821 N. EUTAW ST # 305 BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRY NUMBER
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06921

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Alice Haines Meyer | | | | 2. DATE OF DEATH
MONTH 3 DAY 1 YEAR 95 | | 3. TIME OF DEATH
12:30 PM | |
| 4. SOCIAL SECURITY NUMBER
451 74 6127 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8-1-1913 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Carroll County General Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Westminster | | 8c. COUNTY OF DEATH
Carroll | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Carroll Co | | 10c. CITY, TOWN OR LOCATION
Westminster | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Westminster Nurs & Convnal Home
1234 Washington Road | | | | 10f. ZIP CODE
21157 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Registered Nurse | | 16b. KIND OF BUSINESS/INDUSTRY
Medicine | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Samuel David Haines | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lucinda Virginia Hollenbaugh | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Atty William | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
127 E. Main St, Westminster, MD 21158 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | OATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CARDIOPULMONARY ARREST | | | | | Approximate Interval Between Onset and Death
TIME OF DEATH |
| | | b. ACUTE MYOCARDIAL INFARCTION | | | | | 2 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. CORONARY ARTERY DISEASE and | | | | | 2 YEARS |
| | | d. NECROTIZING Hemorrhagic pancreatitis | | | | | 4 MOS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia, CHT ANASARCA, Depression, Anemia, FAILURE TO THRIVE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Van Heller Schneider MD</i> | | | | 29c. LICENSE NUMBER
D28221 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DOROTHY V. NORTH | | | | 2. DATE OF DEATH
MONTH MAR. DAY 02 YEAR 95 | | 3. TIME OF DEATH
1:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER
212-20-6929 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
70 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH
(Month, Day, Year)
7-19-24 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Bonsecours Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
644 S. PAYSON STREET | | | | 10f. ZIP CODE
21223 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH GRADE
College (1-4 or 5+) HOMEMAKER | | | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
HOMEMAKING | |
| 17. FATHER'S NAME (First, Middle, Last)
THOMAS WRIGHT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
THELMA (UNKNOWN) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MRS. JACQUELINE M. CURRY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3233 MURRAY ROAD LOT 2 - FINKSBURG, MD 21048 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
LOUDON PARK CEMETERY | | OATE
3/6 | | 20c. LOCATION — City or Town, State
BALTIMORE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
M. Thelma Coleman | | | | 22. NAME AND ADDRESS OF FACILITY
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
b. Extensive lung pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. Severe emphysema
DUE TO (OR AS A CONSEQUENCE OF):
d. peripheral vascular disease | | | | | | | |
| Approximate Interval Between Onset and Death
1wk
2wk
5yrs
1yr. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. [Signature] | | | | 29c. LICENSE NUMBER
D29769 | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Inspector J. Albervene a 516 W. Rolling Rd Bw Bbo. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. The funeral home may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. If the death certificate is not filed within 72 hours after death, the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MERLE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 28 1995 | | | | 3. TIME OF DEATH
7:30 AM | |
| 4. SOCIAL SECURITY NUMBER
212-58-1336 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
June 27, 1952 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
DEATON MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | | | 9c. COUNTY OF DEATH | |
| 10a. STATE
MD | | 10b. COUNTY
City | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2542 McHenry Street | | | | 10f. ZIP CODE
21223 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
June 72-April 74 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Forklift Operator | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Merle D. Nicholson, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Agnes Nicholson | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Agnes Nicholson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2542 McHenry Street, Baltimore, Maryland 21223 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest Vet. 13/7/ | | 20c. LOCATION — City or Town, State
Garrison, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
William C. Brown Community Funeral Home
1206-08 W. North Avenue, Balt. Md 21217 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Neck injuries with complications thereof
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
9/25/95 | | 28b. TIME OF INJURY
0240 M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED
Subject struck by train | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Railroad tracks | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
2700 Blk Berlin St. | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 03, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Aaron Locke, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06924

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ethel Marie Parker | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 3 1995 | | 3. TIME OF DEATH
5-20 A-M | |
| 4. SOCIAL SECURITY NUMBER
219-20-6092 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-2-1900 | |
| 8. BIRTHPLACE (State or Foreign Country)
Md. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Union Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | |
| 9c. COUNTY OF DEATH
Balto | | | | 10a. STATE
Md. | | | |
| 10b. COUNTY
Balto | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
501 Dolphin St | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
House Keeping | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Issac Augusta | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Susan Branson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joseph Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
501 Dolphin St. Apt. 1301 Baltimore, Md. 21217 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Auburn | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | 20d. DATE
3/8/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Portia Ebron | | | | 22. NAME AND ADDRESS OF FACILITY
March F/H - West
4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PROBABLE METASTATIC CANCER
DUE TO (OR AS A CONSEQUENCE OF):
b. BREAST CANCER
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
2 WEEKS
10 YEARS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NONE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
R. PAUL, MD | | | | 29c. LICENSE NUMBER
AT 243 8946 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 3 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R. PAUL, UNION MEMORIAL HOSPITAL, 201 E UNIV PKWY, BALTIMORE, MD 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
Julia [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06925

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kathleen Ross | | | | 2. DATE OF DEATH
MONTH 3 DAY 3 YEAR 95 | | 3. TIME OF DEATH
1:45 p M | |
| 4. SOCIAL SECURITY NUMBER
246-38-0166 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept 22, 1928 | |
| 8. BIRTHPLACE (State or Foreign Country)
N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto | |
| 9c. COUNTY OF DEATH
Balto | | | | 10a. STATE
md | | | |
| 10b. COUNTY
Balto | | | | 10c. CITY, TOWN OR LOCATION
Balto | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
5 Candlewood Ct | | | |
| 10f. ZIP CODE
21207 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Unknown | | 16b. KIND OF BUSINESS/INDUSTRY
St. Agnes Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Cooper | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Bakins | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Roland Ross | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Candlewood Ct Balto, md 21207 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Mem. Pk 3/3/95 | | 20c. LOCATION — City or Town, State
Arbutus, md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Blondy Wans | |
| 22. NAME AND ADDRESS OF FACILITY
March F.H. West 4300 Wabash Ave | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John S. Chinn | | | | 29c. LICENSE NUMBER
5509 | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
UMMS Neurosurgery | | | | | | | |
| 31. FILED (Month, Day, Year)
MAR 08 1995 | | | | REGISTRAR'S SIGNATURE
John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


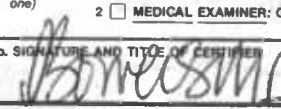
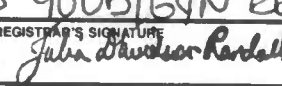
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-06926

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHNE RUTTER | | | | 2. DATE OF DEATH
MONTH 3 DAY 3 YEAR 95 | | 3. TIME OF DEATH
505 P M | |
| 4. SOCIAL SECURITY NUMBER
214-03-5602 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 6, 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Owings Mills | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
132 Pleasant Hill Road | | | | 10f. ZIP CODE
21117 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY
Commercial Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry Rutter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Elizabeth Bowen | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anita S. Rutter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
132 Pleasant Hill Rd., Owings Mills, Md. 21117 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Mem. Gardens 03/06/95 | | 20c. LOCATION — City or Town, State
Finksburg, Md. | | 20d. DATE
03/06/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21117
11605 Reisterstown Rd., Owings Mills, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. RESPIRATORY + CARDIAC ARREST 2nd HYPOXIA | | | | | |
| | | b. PNEUMONIA | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. SUBDURAL HEMATOMA | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY FIBROSIS | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year)
MID-JAN 1995 | | 28b. TIME OF INJURY
UNKNOWN | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28e. DESCRIBE HOW INJURY OCCURRED
FELL DOWN STAIRS | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
OWINGS MILLS, MD. | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TYPE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
AS 240232198130B | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DEBORAH BOWERS 400B/6YN DEPT SINAI HOSPITAL BALTIMORE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
3/3/MAR 6 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

25

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06927

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HOMER W. SAMSELL | | | | 2. DATE OF DEATH
MONTH February DAY 24 YEAR 1995 | | 3. TIME OF DEATH
0400 A M | |
| 4. SOCIAL SECURITY NUMBER
236-22-5590 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JULY 27, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number)
WASHINGTON COUNTY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
HAGERSTOWN | | 9c. COUNTY OF DEATH
Washington | |
| 10a. STATE
WV | | | | 10b. COUNTY
BERKELEY | | 10c. CITY, TOWN OR LOCATION
FALLING WATERS | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
PO BOX 8 | | | | 10f. ZIP CODE
25419 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WORLD WAR II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
INSTRUMENT DEPT. | | 16b. KIND OF BUSINESS/INDUSTRY
FAIRCHILD AIRCRAFT | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHN W. SAMSELL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
KATIE HOUCK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MRS. KATHLEEN SAMSELL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO BOX 8, FALLING WATERS, WV 25419 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ROSEDALE CEMETERY | | DATE
2/27 | | 20c. LOCATION — City or Town, State
MARTINSBURG, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles M. Brown | | | | 22. NAME AND ADDRESS OF FACILITY
BROWN FUNERAL HOME, 327 W. KING ST.
PO BOX 821, MARTINSBURG, WV 25401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe Stroke (Thrombotic?)
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Actual fibrillation?

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
1000936 | | 29d. DATE SIGNED (Month, Day, Year)
2-24-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ME Byrkit MD 28 W Potomac St Williamsport Md 21795 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dear Sir,
I have the honor to acknowledge
the receipt of your letter of the 11th inst.

and in reply to inform you that
the same has been forwarded to the
proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

Yours faithfully,
J. H. [Signature]

95 06928

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Susie Anna Simpson | | | | 2. DATE OF DEATH
MONTH 3 DAY 3 YEAR 95 | | 3. TIME OF DEATH
12:02 a.m. M | |
| 4. SOCIAL SECURITY NUMBER
212-22-8074 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1 17 23 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3305 Ferndale Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
BALTO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTO | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
4 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3305 Ferndale Avenue | | | | 10f. ZIP CODE
21207 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12) 7th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Factory | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Riley Simpson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
George Anna Ormond | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Etta B. Hughes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3305 Ferndale Ave., Baltimore, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)
Woodlawn Cemetery | | DATE
3/8/95 | | 20c. LOCATION — City or Town, State
Baltimore MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
▶ Gladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY
Wm. C. March F/H, West
4300 Wabash Avenue Baltimore, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Carcinoma of the Esophagus
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
5 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Peptic Ulcer Disease, Cholecystitis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Stephen B. Gruber | | | | 29c. LICENSE NUMBER
MS670 | | 29d. DATE SIGNED (Month, Day, Year)
▶ 3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stephen B. Gruber M.D. 600 N. Wolfe St. Baltimore, MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | 32. REGISTRAR'S SIGNATURE
John Henderson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06929

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary A. Stritehoff | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Mar. 1 1995 | | 3. TIME OF DEATH
6:00 A M | |
| 4. SOCIAL SECURITY NUMBER
213-30-1967 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 17, 1931 | |
| 9a. FACILITY NAME (If not institution, give street and number)
7257 Dockside Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Columbia | | 9c. COUNTY OF DEATH
Howard | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Columbia | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7257 Dockside Lane | | | | 10f. ZIP CODE
21045 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Computer Support Technician | | 16b. KIND OF BUSINESS/INDUSTRY
C.&P. Telephone Co. | |
| 17. FATHER'S NAME (First, Middle, Last)
John MacIsaac | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Gill | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Soscia (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7484 Hickory Log Circle, Columbia, MD 21045 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory Mar. 2 1995 | | 20c. LOCATION — City or Town, State
Catonsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>R. C. Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Leroy M & Russell C Witzke Funeral Home
5555 Twin Knolls Rd. Columbia, MD 21045 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small Cell lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death
9 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. T. L. ...</i> | | | | 29c. LICENSE NUMBER
241139 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dept of Medicine Howard County General Hospital, Columbia, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OHMH-16 Rev 1/89

2025-01-14

2025-01-14

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Elizabeth Smith | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1995 | | 3. TIME OF DEATH
9:21 a M | |
| 4. SOCIAL SECURITY NUMBER
N/A | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS
17 | | 7. DATE OF BIRTH (Month, Day, Year)
February 12, 1995 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. COUNTY OF DEATH
N/A | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
Md. | | 10b. COUNTY
Frederick | | 10c. CITY, TOWN OR LOCATION
Frederick | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5601 McDougall St., #14 | | | | 10f. ZIP CODE
21701 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Child | | 16. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Samuel W. Smith, III | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Linda E. Vontz-Bontz | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Linda E. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5601 McDougall St., #14, Frederick, Md. 21701 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Allegany Memorial Cem. 3/06 | | 20c. LOCATION — City or Town, State
Covington, Va. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gary L. Kaufman | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gary L. Kaufman | | 22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Home of Elk., Inc.
5695 Main St., Elkridge, Md. 21227 | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Ventricular Septal Defect
DUE TO (OR AS A CONSEQUENCE OF):
c. Trisomy 13
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death
9 days
17 days
17 days | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Janet L. Kuatkauskas MD | | 29c. LICENSE NUMBER
L4285 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Janet L. Kuatkauskas MD Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
John Andrew Ruffell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06932

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Eleanor J Tubbs</i> | | | | 2. DATE OF DEATH
MONTH <i>MARCH</i> DAY <i>2</i> YEAR <i>1995</i> | | | | 3. TIME OF DEATH
<i>2:15P M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>187 24 9177</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<i>64</i> YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Nov. 13, 1930</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Pennsylvania</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Harbor Hospital Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | |
| 9c. COUNTY OF DEATH
<i>NA</i> | | | | 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>NA</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>4138 Townsend Avenue</i> | |
| 10f. ZIP CODE
<i>21225</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Elementary/Secondary (9-12)</i>
<i>12</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Housewife</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Own Home</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Casimer Rzeminski</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Mary Gresiak</i> | | | | 19a. INFORMANT'S NAME (Type/Print)
<i>William Tubbs</i> | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4138 Townsend Avenue Baltimore, Maryland 21225</i> | | | | 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Holy Cross Cemetery</i> | |
| 20c. LOCATION — City or Town, State
<i>3/4 Baltimore, Maryland</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>C. Richard Horne</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225</i> | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic Lung Cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>b. DUE TO (OR AS A CONSEQUENCE OF):</i>
<i>c. DUE TO (OR AS A CONSEQUENCE OF):</i>
<i>d.</i> | | | | Approximate interval Between Onset and Death
<i>7 mos.</i> | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<i>Russell A. DeLuca</i>
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Russell A. DeLuca</i> | | | | 29c. LICENSE NUMBER
<i>031537</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>MARCH 2, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Russell A. DeLuca 3001 S. Hanover St, Baltimore, Md 21225</i> | | | | 31. DATE FILED (Month, Day, Year)
<i>MAR 06 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson Randall</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06933

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEWYN WEAVER | | | | 2. DATE OF DEATH
MONTH 3 / DAY 2 / YEAR 95 | | 3. TIME OF DEATH
1:20 P M | |
| 4. SOCIAL SECURITY NUMBER
241-36-8449 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Sept 2, 1928 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto | | 9c. COUNTY OF DEATH
Balto | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
md | | 10b. COUNTY
Balto | | 10c. CITY, TOWN OR LOCATION
Balto | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3709 Sequoia Ave | | | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) 2 yrs | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Unknown | | 16b. KIND OF BUSINESS/INDUSTRY
Balto Public Schools | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Levi Weaver | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pearl Mail | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Margaret Weaver | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3709 Sequoia Ave Balto, md 21215 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Druid Ridge | | 20c. DATE
3/2/95 | | 20d. LOCATION — City or Town, State
Balto, md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Portia Ebron | | | | 22. NAME AND ADDRESS OF FACILITY
March F. H. West
4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE (CHRONIC) | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): DM ; HPN | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARDIOMYOPATHY
Hx of ANGIOEDEMA | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
B. M. D. | | | | 29c. LICENSE NUMBER
90 Sinai Hosp. | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BENITO PATARQUE, SINAI HOSP. OF BALTIMORE, BALTIMORE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 10 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | |

ONMN-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR




TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10
10A

95 06934

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Angeline F. Witte | | | | 2. DATE OF DEATH
MONTH March DAY 5 YEAR 1995 | | 3. TIME OF DEATH
7¹⁵ A M | |
| 4. SOCIAL SECURITY NUMBER
217-07-2550 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9/14/19 | |
| 9a. FACILITY NAME (If not institution, give street and number)
16407 Cedar Grove Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Sparks | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
MD | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
County | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7282 Conley St. | | | | 10f. ZIP CODE
21224 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) Unk. College (1-4 or 5+) Unk. | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Crossing Guard | | 16b. KIND OF BUSINESS/INDUSTRY
Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Michael Piskor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Theodora Portaskiewicz | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William Witte | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16407 Cedar Grove Rd. Sparks, MD 21152 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Stanislaus Cem. | | 20c. LOCATION — City or Town, State
3/8 Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
B. Dabrowski & Son Funeral Home
2818 E. Baltimore St. Baltimore, MD 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. Smoking
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval between Onset and Death 8 mo | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D35170 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
808-810 J. CONKLEY ST. BALTO MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 06935

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Virginia M. White</i> | | | | 2. DATE OF DEATH
MONTH <i>Feb</i> DAY <i>28</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>1110 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>227-10-1728</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>73</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>5/30/1921</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>JOHN DEATON NURSING HOME</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>BALTIMORE</i> | | 9c. COUNTY OF DEATH
<i>CITY</i> | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION
<i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE
<i>MARYLAND</i> | | 10b. COUNTY | | 10e. STREET AND NUMBER
<i>611 S. CHARLES STREET</i> | | 10f. ZIP CODE
<i>21230</i> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i>
College (1-4 or 5+) <i>0</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>HOMEMAKER</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>HOMEMAKER</i> | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>CAUCASIAN</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>HARRY B. MOYER SR.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>FLOSSIE MOYER</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>GLADYS G. JERRI ZIMMERMAN</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>320 E. PRINCERS ST, YORK PA. 17403</i> | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>METRO CREMATORY, INC 3/6/95</i> | | 20c. LOCATION — City or Town, State
<i>CATONSVILLE, MD.</i> | | 22. NAME AND ADDRESS OF FACILITY
<i>ESTEP BROTHERS FUNERAL HOME, P.A.
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of larynx</i>

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <i>Hy pontansia</i>
c. <i>Dementia</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | |
| 29c. LICENSE NUMBER
<i>D30494</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>3/1/95</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>DEATON 4660 Wilkens Ave Baltimore MD 21229</i> | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 06 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-0945-510

B.K.S

95 06936

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES WILSON | | | | 2. DATE OF DEATH
MONTH FEB. DAY 22 YEAR 95 | | 3. TIME OF DEATH
0959 A.M. | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
43 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
5/9/51 | | 8. BIRTHPLACE (State or Foreign Country)
MD | |
| 9a. FACILITY NAME (If not institution, give street and number)
2216 ROUND ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
BALTO. CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTO. CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2216 ROUND RD. | | | | 10f. ZIP CODE
21225 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLK. | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DISABLE | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LEALON PRATT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LUCILLE PRATT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LEALON PRATT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
511 ROUNDVIEW RD. BALTIMORE MD 21225 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. ZION CEM. 2/27/95 | | 20c. LOCATION — City or Town, State
BALTO. MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lealon Pratt</i> | | | | 22. NAME AND ADDRESS OF FACILITY
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertensive Cardiovascular Disease
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acquired Immune Deficiency Syndrome | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
XX YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles Locke MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 23, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
JUNIOR | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 27, 1995 | | | | 3. TIME OF DEATH
10:10 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
249-46-5958 | | | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 13, 1933 | | 8. BIRTHPLACE (State or Foreign Country)
South Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
3623 BEEHLER AVENUE | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | | 9c. COUNTY OF DEATH
N/A | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
3623 Beehler Ave. | | | | | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Negro | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Dryer Operator | | | | 16b. KIND OF BUSINESS/INDUSTRY
Textile Plant | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Nelson Ward | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Early Rush | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martha Lowery | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 5-Box 110 AX Sumpter, S.C. 29153 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodlawn 3/4/95 | | | | 20c. LOCATION — City or Town, State
Balto. Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Joseph C. Rush | | | | | | 22. NAME AND ADDRESS OF FACILITY
2222 W North ave 21216 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HANGING
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 26a. DATE OF INJURY (Month, Day, Year)
2/27/1995 | | 26b. TIME OF INJURY
10:10 A M | | 26c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED
SUBJECT HANGED SELF | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
AT HOME | | | | | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)
3623 BEEHLER AVENUE BALTIMORE, MARYLAND | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dennis J. Chute M.D. | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 3, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DENNIS J. CHUTE M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | | | 32. REGISTRAR'S SIGNATURE
John D. ... | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06938

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/17/95 t.t.

blh

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
George W. Wiley | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 24 1995 | | 3. TIME OF DEATH
2311 | |
| 4. SOCIAL SECURITY NUMBER
213-20-7120 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-28-25 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
827 N. Arlington Ave. Apt. 904 | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
NA | | | | 10a. STATE
Maryland | | 10b. COUNTY
na | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
827 N. Arlington Ave #904 | |
| 10f. ZIP CODE
21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Packer/Paper Cutter | | 16b. KIND OF BUSINESS/INDUSTRY
Paper Companies | |
| 17. FATHER'S NAME (First, Middle, Last)
unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mildred Robinson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George W. Wiley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7916 Dunhill Village Cr. Randallstown, Md. 21133 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest Cem. 3/3/95 | | 20c. LOCATION — City or Town, State
Dwings Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY
Unity Funeral Home State Anatomy Board
655 W. Baltimore St, Balto, MD 21201
108 W. North Ave. Balto., Md. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Margaret M. Hull | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
Feb 25 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARGARET M. HULL 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | | | |

95 06939

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AUGUSTA Elizabeth Duncan Wall DUNCAN | | | | 2. DATE OF DEATH 2-27-95
MONTH DAY YEAR | | 3. TIME OF DEATH 8:15A M | |
| 4. SOCIAL SECURITY NUMBER
213 20 3151 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-16-1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Church Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
na | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
na | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2419 E. Madison Street | | | |
| 10f. ZIP CODE
21205 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
William Duncan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Denise Wall Daug | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2419 E. Madison St, Balto, MD 21205 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Andrzej Nazeremi MD | | | | 29c. LICENSE NUMBER
D17322 | | 29d. DATE SIGNED (Month, Day, Year)
2/27/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED FROM

NOV 11 1965

RECEIVED FROM

NOV 11 1965

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SALLIE OWENS ALLISON | | | | 2. DATE OF DEATH
MONTH MAR DAY 4 YEAR 1995 | | 3. TIME OF DEATH
7:40 A M | |
| 4. SOCIAL SECURITY NUMBER
214-18-2436A | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
JUL. 22, 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON, MARYLAND | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5837 BELAIR ROAD | | | | 10f. ZIP CODE
21206 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES XX | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3 RD
College (1-4 or 5+) -- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last)
FRANK OWENS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
DEBRA JOHNSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROSE TAYLOR | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1615 EUTAW PLACE, BALTIMORE, MARYLAND 21217 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY 3-8 | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Bernard D. Johnson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTRIC OBSTRUCTION-POSSIBLE CANCER | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF):
SEPSIS | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
132929 ml | | 29d. DATE SIGNED (Month, Day, Year)
3/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD D'ANTONIO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR


TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

VOID
CERTIFICATE 

95-06941

SEE

CERTIFICATE 



95-8526

95 06942

Item#21. G-film 721 per F.H 3/7/95 P.C

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CARMEN ANDERSEN | | | | 2. DATE OF DEATH
MONTH 3 DAY 1 YEAR 1995 | | 3. TIME OF DEATH
5:50 P M | |
| 4. SOCIAL SECURITY NUMBER
132-26-9260 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/8/29 | |
| 9a. FACILITY NAME (If not institution, give street and number)
University of Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 8. BIRTHPLACE (State or Foreign Country)
PUERTO RICO | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION
GLEN BURNIE | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
7355 RIDGEWATER CT., APT. 201 | | | |
| 10f. ZIP CODE
21060 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify PUERTO RICAN | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SALES | | 16b. KIND OF BUSINESS/INDUSTRY
RETAIL | | | |
| 17. FATHER'S NAME (First, Middle, Last)
EMILIANO MARTINEZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARIANNA GARCIA | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DR. J. D. ALLRED | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7355 RIDGEWATER CT., APT. 201 GLEN BURNIE, MD. 21060 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MD. VETERANS CEMETERY 3/6/95 | | 20c. LOCATION — City or Town, State
CROWNSVILLE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC cancer
a. DUE TO (OR AS A CONSEQUENCE OF):
b. Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael V. Woodbrings M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael V. Woodbrings 22 S. Green St. Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 7 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06943

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEONARD AIKEN | | | | 2. DATE OF DEATH
MONTH FEB. DAY 28 YEAR 1995 | | 3. TIME OF DEATH
2:20 P. | |
| 4. SOCIAL SECURITY NUMBER
214-18-9741 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
FEB. 11, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number)
SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3907 BANCROFT RD. | | | |
| 10f. ZIP CODE
21215 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII - ARMY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
CPA | | 16b. KIND OF BUSINESS/INDUSTRY
ACCOUNTING | | | |
| 17. FATHER'S NAME (First, Middle, Last)
NATHAN AIKEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SARAH BRODNICK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MRS. SYLVIA AIKEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3907 BANCROFT RD. BALTO., MD 21215 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SHAAREI ZION 3/2/1995 | | 20c. LOCATION — City or Town, State
BALTIMORE, MD | | 20d. DATE
3/2/1995 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
6010 REISTERTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → VENTRICULAR ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
a. VENTRICULAR ARRHYTHMIA
b. ARTERIOSCLEROTIC HEART DISEASE
c. ARTERIOSCLEROTIC HEART DISEASE
d. ARTERIOSCLEROTIC HEART DISEASE
Approximate Interval Between Onset and Death
1 HR
10 YRS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
CORONARY ARTERY DISEASE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Howard B. Cohen, M.D.</i> | | | | 29c. LICENSE NUMBER
D 21680 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HOWARD B. COHEN, M.D. 6717 PARK HEIGHTS AVE. BALTO., MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL HOME OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06944

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ADA BROWN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 5, 1995 | | 3. TIME OF DEATH
8:00 a. M | |
| 4. SOCIAL SECURITY NUMBER
218-03-2502 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-29-24 | |
| 8. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
md. | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTO | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
813 N. Washington St. | | | | 10f. ZIP CODE
21205 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> N/A | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Labor | | 16b. KIND OF BUSINESS/INDUSTRY
unemployed | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Michael Gresham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Minnie Bayl | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Denise Dudrec | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
824 N. Broadway BALTO MD 21205 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTO. Come | | 20c. LOCATION — City or Town, State
BALTO. | | 20d. DATE
3/5/95 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Battista Butts | | | | 22. NAME AND ADDRESS OF FACILITY
BETHS. FUNERAL HOME
1120 N. Caroline St. BALTO MD 21202 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Myocardial Infarction | | | | | Approximate Interval Between Onset and Death
5 days |
| | | b. Coronary Artery Disease | | | | | 4 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Emphysema, Hypertension
Chronic Renal Insufficiency | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE NOW INJURY OCCURRED | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER
Robert J. Yacovone MD Medical House Officer | | | | 29c. LICENSE NUMBER
L8603 | | 29d. DATE SIGNED (Month, Day, Year)
3/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Tower 110 Doctors Lounge 600 N. Wolfe St. JH Hospital Balt. MD 21236 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1232-510

DWG

Item 1 3-7-95 Film G721 W.H.Per F/H

95 06945

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/30/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DARIEN Lamont Buckner Benson BUCKNER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 04 95 | | 3. TIME OF DEATH
1219P M | |
| 4. SOCIAL SECURITY NUMBER
n/a | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS
3 26 | | 7. DATE OF BIRTH
(Month, Day, Year)
NOV. 6, 1994 | |
| 9a. FACILITY NAME (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2206 HENNEMAN AVENUE | | | | 10f. ZIP CODE
21213 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) none
College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
BABY | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last)
KIP BENSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANTOINETTE BUCKNER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CARLOLETTA BENSON JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2206 HENNEMANN AVENUE, BALTIMORE, MD 21213 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY 3-10 | | 20c. LOCATION — City or Town, State
BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Bernard D. Johnson | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | |
|---|--|---|--|
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME
DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
M
28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Theodore M. King | | 29c. LICENSE NUMBER
O.C.M.E. | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Theodore M. King 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 05/95 | |
| 31. DATE FILLED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
John A. ... | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06946

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLARA N. BISHOFF | | | | 2. DATE OF DEATH
MONTH 03 DAY 04 YEAR 95 | | 3. TIME OF DEATH
1520 P M | |
| 4. SOCIAL SECURITY NUMBER
216-03-9393 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-19-05 | |
| 8. BIRTHPLACE (State or Foreign Country)
MD | | | | 9a. FACILITY NAME (If not institution, give street and number)
Union Memorial Hosp. - ECU | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8227 McDONOUGH RD | | | | 10f. ZIP CODE
21208 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY
Textile | |
| 17. FATHER'S NAME (First, Middle, Last)
N. A. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
N. A. | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Harlan Cress | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8227 McDonough Road Pikesville, Maryland 21208 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Centenary Cemetery 4/7 | | 20c. LOCATION — City or Town, State
Bruceton Mills, West Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael P. Marzullo | | | | 22. NAME AND ADDRESS OF FACILITY
Marzullo Funeral Service
3981 Carrollton Road Upperco, Maryland 21155 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Richard Diamond | | | | 29c. LICENSE NUMBER
D23-76 | | 29d. DATE SIGNED (Month, Day, Year)
3-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
3730 Falls Rd Balt Md 21211 RICHARD DIAMOND | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 11 1995 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSEPH H. BERMAN | | | | 2. DATE OF DEATH
MONTH FEB DAY 28 YEAR 95 | | 3. TIME OF DEATH
5:02A M | |
| 4. SOCIAL SECURITY NUMBER
213-09-4626 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
APR. 13, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9. COUNTY OF DEATH
N/A | | | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2434 W. BELVEDERE AVE. | | | |
| 10f. ZIP CODE
21215 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII-NAVY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TECHNICIAN | | 16b. KIND OF BUSINESS/INDUSTRY
WESTINGHOUSE ELECTRIC CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
MAX BERMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
REBECCA PUMPIAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MR. HAROLD BERMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2705 HANSON AVE BALTIMORE, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SHAAREI TFILOH | | 20c. LOCATION — City or Town, State
3-2-95 BALTIMORE, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Joel D Lewis | |
| 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC. | | 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROBABLE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

ATRIAL FIBRILLATION
POLYCYTHEMIA VERA | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
SETH HTWAR ATTENDING PHYSICIAN | | 29c. LICENSE NUMBER
D 25610 | | 29d. DATE SIGNED (Month, Day, Year)
2-18-95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LEVINDALE 2434 W. BELVEDERE AVENUE BALTIMORE MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
John A. Buckner-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06948

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Benjamin Brown | | | | 2. DATE OF DEATH
MONTH 3 DAY 2 YEAR 95 | | 3. TIME OF DEATH
8:30 A M | |
| 4. SOCIAL SECURITY NUMBER
249-10-5537 | | 5. SEX
XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-26-10 | |
| 8. BIRTHPLACE (State or Foreign Country)
Winsboro, S.C. | | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9b. COUNTY OF DEATH
n/a | |
| 9c. FACILITY NAME (If not institution, give street and number)
Liberty Medical Center | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2239 W. Lexington Street | | | | 10f. ZIP CODE
21223 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) Longshoreman | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Longshoreman | | 17. KIND OF BUSINESS/INDUSTRY
Steamship Trade Assoc. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Hillard Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice Brown Simms | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Hannah Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2239 W. Lexington Street Balto., Md. 21223 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland National 3-8-95 Laurel, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Leroy O. Dyett | | | | 22. NAME AND ADDRESS OF FACILITY
Leroy O. Dyett & Son Funeral Home 4600 Liberty Heights Avenue | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Blatant Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Respiratory Failure | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Lance L. Larkins | | | | 29c. LICENSE NUMBER
D37203 | | 29d. DATE SIGNED (Month, Day, Year)
3-2-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Lance L. Larkins Liberty Medical Center, Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06949

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Henry Butler | | | | 2. DATE OF DEATH
MONTH 3 DAY 2 YEAR 95 | | 3. TIME OF DEATH
7:30 p.m. | |
| 4. SOCIAL SECURITY NUMBER
159-34-7582 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-08-1918 | |
| 9a. FACILITY NAME (If not institution, give street and number)
2004 N. Monroe Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE
MARYLAND | | 10b. COUNTY | | 10e. STREET AND NUMBER
2004 N. Monroe Street | | 10f. ZIP CODE
21217 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1942-1945 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th grade
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Cook | | 16b. KIND OF BUSINESS/INDUSTRY
UNKNOWN | |
| 17. FATHER'S NAME (First, Middle, Last)
ALLEN BISHOP | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MINNIE DAVIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
RICHARD SMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3715 Park Heights Avenue Baltimore Maryland 21215 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GARRISON FOREST VETERANS 3/7 | | 20c. LOCATION — City or Town, State
OWINGS MILLS, MARYLAND | | 22. NAME AND ADDRESS OF FACILITY
WILLIAM C. BROWN COMMUNITY F/H
1206 W. North Avenue | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles H. H. H.</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Atherosclerotic Coronary Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c. Alcohol Abuse
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Greg. Rossini MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gregory Rossini MD, Baltimore VA Medical Center House Staff | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John D. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1
2

Gregory Rossini, MD, Baltimore VA Medical Center, H&H staff

3/2/82

Gregory Rossini/DR

X

X

X

X

Alcohol Abuse
Hypertension
Atherosclerotic Coronary Heart Disease

Charles H. Jones

1206 W. North Avenue
WILLIAM C. BROWN COMMUNITY F/H
GARRISON FOREST VETERANS 377 OWINGS MILLS, MARYLAND
3715 Park Heights Avenue Baltimore Maryland 21212

RICHARD SMITH
X

ALLEN BISHOP

10th grade

Cook

UNKNOWN

MINNIE DAVIS

1945-1946 XX

2004 N. Monroe Street

21217

U.S.A.

BLACK

X

BALTIMORE CITY

XX

BALTIMORE CITY

2004 N. Monroe Street

26

11-08-1918

South Carolina

121-34-228 X
Henry Butler

3 2 7:30 p

95 06950

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ronald Brown | | | | 2. DATE OF DEATH
MONTH March DAY 2 YEAR 95 | | 3. TIME OF DEATH
1:40 A-M | |
| 4. SOCIAL SECURITY NUMBER
217-52-6697 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
SEPT. 23, 1950 | |
| 8a. FACILITY NAME (If not institution, give street and number)
BAYVIEW MEDICAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 8c. COUNTY OF DEATH
n/a | |
| 9a. STATE
MARYLAND | | 9b. COUNTY
n/a | | 9c. CITY, TOWN OR LOCATION
BALTIMORE | | 9d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER
1034 WILMONT COURT | | | | 10f. ZIP CODE
21202 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES XX | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 TH
College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last)
HARRIS BROWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
PEARLINE TAYALL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DENISE BROWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1034 WILMONT COURT, BALTIMORE, MD 21202 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | | 20d. DATE
3-7 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
See V. Holland | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Retroviral Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Naomi P. O'Grady MD | | | | 29c. LICENSE NUMBER
35-06-8249 | | 29d. DATE SIGNED (Month, Day, Year)
3-7-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Naomi P. O'Grady, MD 4440 Eastern Ave Baltimore MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06951

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROY BERRY | | | | 2. DATE OF DEATH
MONTH 03 DAY 05 YEAR 95 | | 3. TIME OF DEATH
0330 A M | |
| 4. SOCIAL SECURITY NUMBER
217-18-9324 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-7-1922 | |
| 9a. FACILITY NAME (If not institution, give street and number)
HOPKINS BAYVIEW M.C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE CO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1610 FOUR GEORGES COURT | | | | 10f. ZIP CODE
21222 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
CRANE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY
Bethlehem Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Berry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
PATRICIA ANN SWIGON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2120 JASMINE RD. BALTO MD 21222 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
OAKLAWN CEMETERY 3/8/95 | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | | 22. NAME AND ADDRESS OF FACILITY
JOSEPH N. ZANNINO JR. FUNERAL HOME
263 S. CONKLING ST. BALTO MD 21224 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles J. Zannino</i> | | | | 22. NAME AND ADDRESS OF FACILITY
JOSEPH N. ZANNINO JR. FUNERAL HOME
263 S. CONKLING ST. BALTO MD 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. METASTATIC LUNG CANCER | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. ACUTE RENAL FAILURE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James O. Gandy MD</i> | | | | 29c. LICENSE NUMBER
BS 399127 | | 29d. DATE SIGNED (Month, Day, Year)
3/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michelle Stowe ONG, JOHN HOPKINS BAYVIEW MEDICAL CTR | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Rodall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06952

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ERNEST JOSEPH BARATH | | | | 2. DATE OF DEATH
MONTH MARCH DAY 2 , YEAR 1995 | | 3. TIME OF DEATH
5:57A M | |
| 4. SOCIAL SECURITY NUMBER
217-24-2041 | | 5. SEX
XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
06-10-1929 | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION
PASADENA | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7618 COLONIAL BEACH ROAD | | | | 10f. ZIP CODE
21122 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MOLD MAKER | | 16b. KIND OF BUSINESS/INDUSTRY
GLASS COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LOUIS BARATH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ISABELLE FIXMER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LARRY DENNIS BARATH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21122
7607 COLONIAL BEACH ROAD, PASADENA, MD. | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MEADOWRIDGE MEMORIAL PK 3/6/95 | | 20c. LOCATION — City or Town, State
ELKRIDGE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
SINGLETON FUNERAL HOME,
1 SECOND AVENUE, S.W.
GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Upper gastrointestinal bleed | | | | | Approximate interval Between Onset and Death
2 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Portal hypertension | | | | | 1-2 years |
| | | c. Sclerosing cholangitis | | | | | 15 years |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ulcerative colitis | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

J. H. N. White | | | | 29c. LICENSE NUMBER
L-4761 | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Power J H N White St Balt MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06953

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WALTER CARL BLATT, Jr. | | | | 2. DATE OF DEATH
MONTH 3 DAY 1 YEAR 95 | | 3. TIME OF DEATH
1:11 a.m. | |
| 4. SOCIAL SECURITY NUMBER
218-28-6856 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8-26-25 | |
| 8. BIRTHPLACE (State or Foreign Country)
Missouri | | | | 9a. FACILITY NAME (If not institution, give street and number)
5010 Byerly Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Upperco | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
7 Windblown Ct. | |
| 10f. ZIP CODE
21209 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ yrs | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Executive | | 16b. KIND OF BUSINESS/INDUSTRY
Heating and Air Conditioning | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter Carl Blatt, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Laubis | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Gibson Bell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
324 Central Ave, Glydon, Md. 21071 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Corp. 3-4 | | 20c. LOCATION — City or Town, State
Towson, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Transitional Carcinoma of Prol Peltis</u>
DUE TO (OR AS A CONSEQUENCE OF):
b.
c.
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
7 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Renal Failure, Brain Met</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D30925 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
Dr. Paul Celano 6569 N. Charles St. | | | | | | | |
| 31. DATE
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06954

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
IRIS L. BIEDERMAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1995 | | 3. TIME OF DEATH
4:30 AM | |
| 4. SOCIAL SECURITY NUMBER
215-46-5346 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAY 3, 1946 | |
| 9a. FACILITY NAME (If not institution, give street and number)
8 STATION CIRCLE CT. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
OWINGS MILLS | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
OWINGS MILLS | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8 STATION CIRCLE CT. | | | | 10f. ZIP CODE
21117 | | 10g. CITIZEN OF WHAT COUNTRY?
US | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
AT HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
MILTON GOLDSMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FANNIE MAIER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
RONALD D. BIEDERMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 STATION CIRCLE CT. OWINGS MILLS MD 21117 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
CHEVRA AHAVAS CHESSED 3-2-95 | | 20c. LOCATION — City or Town, State
RANDALLSTOWN MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GLIOBLASTOMA MULTIFORME
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D28595 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TABNEEM LAKITANI, 7220 PARK HEIGHTS AVE, BALTO MD 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06955

ITEM: 1. PER F.H. FILM G-721 3/7/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>ROSA B. CHRISTIAN</u> | | | | 2. DATE OF DEATH
MONTH <u>3</u> DAY <u>3</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>2:55a. M</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>220 244 482</u> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
<u>88</u> YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | 7. DATE OF BIRTH (Month, Day, Year)
<u>Apr. 16, 1906</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Church Homes Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Baltimore</u> | | 9c. COUNTY OF DEATH
<u>N/A</u> | |
| 10a. STATE
<u>MD</u> | | | | 10b. COUNTY
<u>N/A</u> | | 10c. CITY, TOWN OR LOCATION
<u>BALTIMORE</u> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>2511 E. CHASE STREET</u> | | | |
| 10f. ZIP CODE
<u>21213</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
<u>4th</u> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Domestic</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>n/a</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>UNKNOWN</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Amanda Carroll</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>RECEMARY ANDERSON</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3017 Chelsea Terrace/Baltimore, MD 21216</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Arbutus Memorial Park</u> | | DATE
<u>3-8</u> | | 20c. LOCATION — City or Town, State
<u>Arbutus, MD</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
<u>March Funeral Home East</u>
<u>1101 E. North Avenue/Baltimore, MD 21202</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Perforated bowel</u> DUE TO (OR AS A CONSEQUENCE OF):
c. <u>multiple decubitus ulcers</u> DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
<u>616402</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>3/3/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Y. K. SHETTY 100 N. Broadway, BALT MD 21231</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR 7 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RESEARCH BOARD

RESEARCH BOARD

RESEARCH BOARD

95-1051-510
B.K.S

95 06956

ITEMS: 27, 28b, 28d, 28f, PER MEO FILM G-721 3/17/95 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
AVIS COVINGTON | | | | 2. DATE OF DEATH
MONTH FEB. DAY 27 YEAR 95 | | 3. TIME OF DEATH
8:48 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER
212-884922 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
18 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
11-30-76 | | 8. BIRTHPLACE (State or Foreign Country)
md | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
918 WEBB COURT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | | | 9c. COUNTY OF DEATH
N/A | | | |
| 10a. STATE
md | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTO. | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1500 N. Broadway Apt. 2 | | | | 10f. ZIP CODE
21213 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR OATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) <input checked="" type="checkbox"/> College (14 or 15+) <input type="checkbox"/> N/A | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
unemployed | | 15b. KIND OF BUSINESS/INDUSTRY
N/A | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Bobby Lunsford | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Attolene Covington | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Shirley Hachett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1500 N. Broadway Apt. 2 BALTO MD 21213 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SACRED HEART MARY PT 30/15 BALTO MD | | OATE | | 20c. LOCATION — City or Town, State
BALTO MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Patricia Bitt | | | | 22. NAME AND ADDRESS OF FACILITY
BETHS FUNERAL HOME 1211 N. CALHOUN ST. BALTO MD 21213 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Head
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year)
2/27/95 | | 28b. TIME OF INJURY
(Month, Day, Year)
8:43 PM | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
subject shot HERSELF | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Home | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
918 Webb Ct BALTIMORE MD | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Shirley J. Chute | | | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
FEB. 28, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia A. Hatcher-Kendall | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EUNICE M. CARSKI | | | | 2. DATE OF DEATH
MONTH MARCH DAY 4 YEAR 1995 | | 3. TIME OF DEATH
10:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER
216-16-9669 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH
MONTH 04 , DAY 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2419 Saratoga Avenue | | 10f. ZIP CODE
21227 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12-th | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Hospital | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Eugene Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eunice Leatherbury Myster | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James Lawrence Taylor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2529 W. Lafayette Ave. Baltimore, MD 21216 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 03/06/95 | | 20c. LOCATION — City or Town, State
Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Dawn F. McDonald | | | | 22. NAME AND ADDRESS OF FACILITY
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RESPIRATORY FAILURE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. LUNG CA WITH RIGHT PLEURAL EFFUSION 1YR. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. _____ | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DIS. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
R. ANG JR. - RES. PHYS. | | | | 29c. LICENSE NUMBER
AS244161425 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 4 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ROMEO M. ANG JR. 3001 S. HANOVER ST. BALTIMORE MD 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. Wilson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06958

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SARA CRIST | | | | 2. DATE OF DEATH
MONTH 3 DAY 2 YEAR 95 | | 3. TIME OF DEATH
10:30 P M | |
| 4. SOCIAL SECURITY NUMBER
216-07-2161 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-19-14 | |
| 8. BIRTHPLACE (State or Foreign Country)
virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
RIVERVIEW NURSING CENTRE, INC. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Essex | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
Md. | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Essex | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
1 Eastern Ave. | |
| 10f. ZIP CODE
21221 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) Housewife | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
own home | |
| 17. FATHER'S NAME (First, Middle, Last)
Philip Brawner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clyde Amidone | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wes Hart | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Homburg Ave. Baltimore MD. 21221 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holly Hill Cemetery 3/6/95 Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
R. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | Approximate interval Between Onset and Death
unknown | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael Schwartz | | | | 29c. LICENSE NUMBER
D19667 | | 29d. DATE SIGNED (Month, Day, Year)
3-3-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Michael Schwartz Berdann Medical Group 606 Hammonds Lane 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John Anderson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REV. C. J. FORD

REV. C. J. FORD

Wm. L. Ford

95 06959

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Cornelia Coliano | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 02 1995 | | 3. TIME OF DEATH
7:50 a.m. | |
| 4. SOCIAL SECURITY NUMBER
216-01-8455 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-17-13 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Fallston | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1113 Peachtree Rd. | | | | 10f. ZIP CODE
21047 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Cheif Republican Registrar | | 16b. KIND OF BUSINESS/INDUSTRY
Baltimore City Board of Elections | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Corneilius Busch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara Funk | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Louis J. Coliano, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1113 Peachtree Rd. Fallston, Md. 21047 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gardens 3-6 | | 20c. LOCATION — City or Town, State
Timonium, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PARKINSON'S DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
10 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
a <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D-12849 | | 29d. DATE SIGNED (Month, Day, Year)
3-2-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A.R. GHILADI, M.D. 7600 OSLER Dr. Towson Md. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1050 York Rd. Towson, Md. 21204
Towson Funeral Home, Inc.

95 06960

ITEM: 20b, PER F.H. FILM G-721 3/7/95 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SHIRLEY ANN COLEMAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 1995 | | 3. TIME OF DEATH
HOURS MINUTES
2:20 a | |
| 4. SOCIAL SECURITY NUMBER
217-56-9592 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAR 26, 1952 | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
n/a | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
5001 CONANT WAY APT.G | | | |
| 10f. ZIP CODE
21206 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DATA PROCESSOR | | 16b. KIND OF BUSINESS/INDUSTRY
STATE OF MARYLAND | | | |
| 17. FATHER'S NAME (First, Middle, Last)
OSCAR HOUSE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY ROBINSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MICHAEL COLEMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5001 CONANT WAY APTC, BALTIMORE, MARYLAND # 06 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | DATE
3-6 | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Synette K. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Pulmonary edema
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Coronary artery disease | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Mark Lewis M.D. | | | | 29c. LICENSE NUMBER
M6321 | | 29d. DATE SIGNED (Month, Day, Year)
2/28/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mark Lewis 110 Tower Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997-1998

95 06961

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Kath Eline Crowder</i> | | | | 2. DATE OF DEATH
MONTH <i>MAR</i> DAY <i>01</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>12.20</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>219-32-8015</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>69</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>9/25/1925</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>N. Carolina</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>St. Agnes Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | |
| 9c. COUNTY OF DEATH
<i>n/a</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>n/a</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>507 N. Longwood Street</i> | |
| 10f. ZIP CODE
<i>21223</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>3</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Nurse's Aide</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Jewish Family Center</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Arren Bennett</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Mary Ratliff</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Jamie Crowder</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5503 Belle Avenue Baltimore, Md. 21207</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Baltimore National Cem. 3/6/95</i> | | 20c. LOCATION — City or Town, State
<i>Baltimore, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leroy Dyett & Son</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>LEROY O. DYETT & SON FUNERAL HOME 6400 Liberty Hght apt</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypotension, shock</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| <i>Acute Renal Failure, UTI</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| <i>Upper GI bleeding</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| <i>Liver cirrhosis, Ascites, Alcoholism</i> | | | | | | | |
| Approximate Interval Between Onset and Death
<i>2 min</i>
<i>12 hr</i>
<i>5 min</i>
<i>>10 yr.</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>WADD Memor ER.</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Eric Redeker MED RESIDENT M.D.</i> | | | | 29c. LICENSE NUMBER
<i>201892</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>3/1/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>EWA RACHOCKA ST AGNES HOSPITAL 900 CATON AVE BALTIMORE MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06962

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY C. CARUSO | | | | 2. DATE OF DEATH
MONTH MARCH DAY 6 YEAR 1995 | | 3. TIME OF DEATH
7:20 PM | |
| 4. SOCIAL SECURITY NUMBER
216-01-1643 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
SEPTEMBER 1, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
BAY MEADOW NURSING AND REHAB. CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
GLEN BURNIE, MARYLAND | | 9c. COUNTY OF DEATH
MARYLAND | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
----- | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1402 JACKSON STREET | | | | 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 7TH
College (1-4 or 5+) ----- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
PACKER | | 16b. KIND OF BUSINESS/INDUSTRY
FRUIT COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ALBERT LORENZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANNIE SEIFERT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
EDWARD L. CARUSO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1402 JACKSON STREET, BALTIMORE, MD 21230 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
CROWNSVILLE VA CEMETERY, MARCH 8, 1995, CROWNSVILLE, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Victor P. Dade Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
CHARLES L. STEVENS FUNERAL HOME, INC.
1501 E. FORT AVENUE, BALTIMORE, MD 21230 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → 1) Respiratory Failure 2° to
DUE TO (OR AS A CONSEQUENCE OF):
2) Metastasis of Ca Colon to Liver + Lung
DUE TO (OR AS A CONSEQUENCE OF):
3) ASCO
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Carlos D. Atascu</i> | | | | 29c. LICENSE NUMBER
D18426 | | 29d. DATE SIGNED (Month, Day, Year)
3/7/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
DR. B. ATASCU, AGE DOCT. MD 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 06963

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANNA CAMPBELL | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 95 | | | | 3. TIME OF DEATH
20:33 P M | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
218-44-9968 a | | | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
MAY 6, 1918 | | 8. BIRTHPLACE (State or Foreign Country)
N. CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | | | 9c. COUNTY OF DEATH
n/a | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
n/a | | | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
925 N. BROADWAY APT. 203 | | | | | | | | 10f. ZIP CODE
21205 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
3 RD - | | | | | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
BOYED NICHOLS | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARITY CATES | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CLARENCE CAMPBELL | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
925 N. BROADWAY, BALTIMORE, MD 21205 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE
GARRISON FOREST VA CEMETERY 3-6 OWINGS MILLS, MD | | | | | | | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Synette K. Jones</i> | | | | | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Possible cardiac arrhythmias</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia</i> | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Smith K. Trampenauer</i> | | | | | | | | 29c. LICENSE NUMBER
D30661 | | | | 29d. DATE SIGNED (Month, Day, Year)
March 3, 1995 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | | 32. REGISTRAR'S SIGNATURE
<i>Jolin Anderson-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ARTHUR E. CRUM | | | | 2. DATE OF DEATH
MONTH 3 DAY 5 YEAR 1995 | | 3. TIME OF DEATH
4:35 a m | |
| 4. SOCIAL SECURITY NUMBER
214-01-5228 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
7-24-1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON, MARYLAND | |
| 9c. COUNTY OF DEATH
BALTIMORE | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore | | | | 10c. CITY, TOWN OR LOCATION
TOWSON | | | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
7700 YORK ROAD | | | |
| 10f. ZIP CODE
21204 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Air Conditioning Maint. | | 16b. KIND OF BUSINESS/INDUSTRY
Nellis Air Force | |
| 17. FATHER'S NAME (First, Middle, Last)
Jessie E. CRUM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Wilhemina Roelke | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John & Kathryn Goets | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RD 2 6618 Brighton Dr. Seven Valleys Pa. 17360 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
LORRAINE PARK CEM 3-8 | | 20c. LOCATION — City or Town, State
Baltimore Md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles J. Gorman | |
| 22. NAME AND ADDRESS OF FACILITY
Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Baltimore Md 21224 | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA

a. DUE TO (OR AS A CONSEQUENCE OF):

b. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Approximate Interval Between Onset and Death
2 DAYS

2 DAYS | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ADVANCED DEMENTIA
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John & Kathryn Goets | | | | 29c. LICENSE NUMBER
D 37254 | | 29d. DATE SIGNED (Month, Day, Year)
3-5-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. BOON P. LIM, MD 7620 YORK ROAD TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. Russell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020



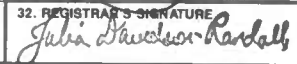
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06965

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Dorothy Rebecca CARROLL | | | | 2. DATE OF DEATH
MONTH March DAY 3 YEAR 1995 | | 3. TIME OF DEATH
8:11 pm | |
| 4. SOCIAL SECURITY NUMBER
212-74-8265 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 1, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Frederick Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Frederick | | 9c. COUNTY OF DEATH
Frederick | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD. | | 10b. COUNTY
FREDERICK | | 10c. CITY, TOWN OR LOCATION
FREDERICK | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
24 LINCOLN APTS. | | | | 10f. ZIP CODE
21701 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 TH
College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY
CHILD CARE SERVICES | | | |
| 17. FATHER'S NAME (First, Middle, Last)
UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
IRENE CARROLL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
HELEN CARROLL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
151 WEST ALL SAINTS ST. FREDERICK, MD. 21701 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FAIRVIEW CEMETERY MAR. 8, 1995 | | 20c. LOCATION — City or Town, State
FREDERICK, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
GARY L. ROLLINS FUNERAL HOME
100 WEST ALL SAINTS ST FREDERICK MD 21701 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
Years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D35164 | | 29d. DATE SIGNED (Month, Day, Year)
March 4, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Andrew Zarick, Jr., M.D., P.O. Box 369, Walkersville, Maryland 21793-0369 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 7 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Ruth A. DUNDON</i> | | | | 2. DATE OF DEATH
MONTH <i>3</i> DAY <i>2</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>5:29</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>213 10 9545</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>90</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>08 14 04</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Hopkins Geriatric Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | 9c. COUNTY OF DEATH
<i>N/A</i> | |
| 10a. STATE
<i>Md.</i> | | | | 10b. COUNTY
<i>N/A</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>340 South Highland Avenue</i> | | | |
| 10f. ZIP CODE
<i>21224</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Sales</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Retail</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>William Fielder Austin</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Mary Elizabeth Schroeder</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Margaret Gull</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>638 S. Streeper St. Balto., Md. 21224</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Oak Lawn Cemetery 3-6-95</i> | | 20c. LOCATION — City or Town, State
<i>Eastwood, Md.</i> | | 20d. DATE
<i>3-6-95</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles S. Zeiler</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Charles S. Zeiler & Son Inc.
901 S. Conkling St. Balto., Md.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic cancer</i>
DUE TO (OR AS A CONSEQUENCE OF):
a. <i>Metastatic cancer</i>
b. <i></i>
c. <i></i>
d. <i></i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Trucane</i> | | | | 29c. LICENSE NUMBER
<i>D24334</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>3/2/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Trucane</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Ruffell</i> | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR TO THE FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must complete and file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
George W. Daniels III | | | | 2. DATE OF DEATH
MONTH 3 DAY 4 YEAR 95 | | 3. TIME OF DEATH
1:57 A.M. | |
| 4. SOCIAL SECURITY NUMBER
212-70-8851 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11, 23, 1957 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Mercy Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10e. STREET AND NUMBER
9-C West Preston Street | | | | 10f. ZIP CODE
21201 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Payroll Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Insurance Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George William Daniels Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Toni Gresdo | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Toni Welling | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
801 Lynnlee Drive Aberdeen, Md. 21001 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Green Mount Crematory 3-6-95 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles S. Zeiler | | | | 22. NAME AND ADDRESS OF FACILITY
Charles S. Zeiler & Son Inc.
901 S. Conkling St. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| a. Acquired Immuno Deficiency Syndrome
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Pneumocystis carinii pneumonia
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Kaposi's sarcoma
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 8 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael V. Woodbridge MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
3/4/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MICHAEL WOODBRIDGE 22 S. GREENE ST BALTIMORE MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 06968

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>William C. Donnelly</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>February 28 1995</i> | | 3. TIME OF DEATH
<i>1224 P M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>212-30-8481</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>82</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>05-07-12</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>UNION MEMORIAL HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>BALTIMORE CITY</i> | | 9c. COUNTY OF DEATH
<i>MARYLAND</i> | |
| 10a. STATE
<i>MARYLAND</i> | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
<i>BALTIMORE CITY</i> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>3213 FRISBY STREET</i> | | 10f. ZIP CODE
<i>21218</i> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>WHITE</i> | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12 YEARS</i>
College (1-4 or 5+) <i>College</i> | |
| 16. KIND OF BUSINESS/INDUSTRY
<i>U.S. POSTAL SERVICE</i> | | | | 17. FATHER'S NAME (First, Middle, Last)
<i>WILLIAM J. DONNELLY</i> | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>AMILIA WEISE</i> | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>EDNA M. DONNELLY (WIFE)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3213 FRISBY STREET, BALTIMORE, MD., 21218</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>DULANEY VALLEY M. GARD. 3-3</i> | | 20c. LOCATION — City or Town, State
<i>TIMONIUM, MD. 21093</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>R. J. L...</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>HENRY W. JENKINS & SONS
4905 YORK ROAD, BALTIMORE, MD. 21212</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| e. <i>Pneumonia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Brainstem Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Steven Yee MD</i> | | | | 29c. LICENSE NUMBER
<i>AT 2438946</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>March 1, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Steven Yee MD 201 E. University Pkwy, Baltimore MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane Williams</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06969

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DOROTHY A. DURKIN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 05, 1995 | | | | 3. TIME OF DEATH
1:30 A M | | | |
| 4. SOCIAL SECURITY NUMBER
212-30-7180 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 12, 1914 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL ASSOCIATION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
GLEN BURNIE | | | | 9c. COUNTY OF DEATH
A.A. COUNTY | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
None | | 10c. CITY, TOWN OR LOCATION
Balto. City, Md. | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1136 Scott St. | | | | 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th. Grade
College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Assembly Line | | 16b. KIND OF BUSINESS/INDUSTRY
Style Kraft Co. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles nmnn O'Neill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Agnes nmnn Hirsch | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Edward J. Durkin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1136 Scott St. Balto. Md. 21230 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Crownsville Vet. Cem. 3/9/95 Crownsville, Md. | | 20c. LOCATION — City or Town, State | | 20d. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Daniel A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → WROSEPSIS
s. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: few days | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral vascular disease
Anemia, dementia, hypertension | | | | | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M. Delaney</i> | | | | 29c. LICENSE NUMBER
D-40521 | | 29d. DATE SIGNED (Month, Day, Year)
3/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MAHESH S. OCHANAY, M.D. 7845 OAKWOOD ROAD #200 GLEN BURNIE, MD 21061 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Stuchlik-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


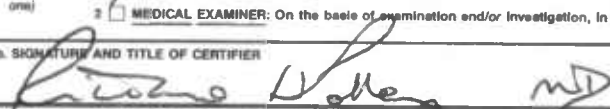
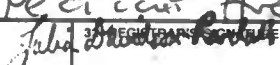
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06970

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ruth Naomi Davis | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 23, 1995 | | 3. TIME OF DEATH
10 P M | |
| 4. SOCIAL SECURITY NUMBER
579-40-1533 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 9, 1933 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
11220 Markwood Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | |
| 10c. CITY, TOWN OR LOCATION
Silver Spring | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
11220 Markwood Drive | |
| 10f. ZIP CODE
20902 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Hamemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Rein | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Adele Maizel | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Gary S. Davis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14102 Bramble Court, Laurel, MD 20708 #T-2 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
B'Nai Israel Cem. 2/26/95 | | 20c. LOCATION — City or Town, State
Oxon Hill, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ives-Pearson Funeral Homes
Falls Church, VA 22046 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARCINOMA OF THE RECTUM</u>
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death 3 mo.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 MD | | | | 29c. LICENSE NUMBER
D09577 | | 29d. DATE SIGNED (Month, Day, Year)
2/25/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
10800 Connecticut Ave Kensington, MD 20895 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)
<i>George S. Eaton</i> | | | | 2. DATE OF DEATH
MONTH <i>03</i> DAY <i>05</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>2:40 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>215 091 392</i> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>77</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>04/20/18</i> | |
| 8. FACILITY NAME (If not institution, give street and number)
<i>Good Samaritan Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | 9c. COUNTY OF DEATH
<i>N/A</i> | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>N/A</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
<i>3237 Dudley Avenue</i> | | | | 10f. ZIP CODE
<i>21213</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2 years</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Typesetter</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Pring Printing Co.</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>George R. Eaton</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Minnie R. Reed</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Audrey B. Eaton (Wife)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3237 Dudley Avenue, Baltimore, Md. 21213</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Green Mount Crematory 3/6/95</i> | | 20c. LOCATION — City or Town, State
<i>Baltimore, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Md. 21213</i> | | | |
| 23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
<i>a. Cerebrovascular accident</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>b. Peripheral Vascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>c.</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>d.</i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
<i>P-07618</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>03/05/95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Ziad ABBUD 1740 2nd Ave, Apt 5A NJ NJ 10128</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1945-1946

95 06972

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DARLYN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 1, 1995 | | | | 3. TIME OF DEATH
8:40 P M | | | |
| 4. SOCIAL SECURITY NUMBER
215-46-8226 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
46 | | IF UNDER 24 HRS.
HOURS MIN.
46 | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | | | 9c. COUNTY OF DEATH
N/A | | | |
| 10a. STATE
MD | | | | 10b. COUNTY
N/A | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
815 Whitelock Street | | | | 10f. ZIP CODE
21217 | | | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) N/A
College (1-4 or 5+) 2 yrs. | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | 17. FATHER'S NAME (First, Middle, Last)
Elliott Chase | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Burlean Wilkenson | | | | 19a. INFORMANT'S NAME (Type/Print)
Ronald Epps | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
815 Whitelock Street/Baltimore, MD 21217 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodlawn Cemetery 3-6 | | | | 20c. LOCATION — City or Town, State
Woodlawn, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Francis [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
March Funeral Home East
1101 E. North Avenue/Baltimore, MD 21202 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Liver Failure
Alcohol Dependency
Renal failure | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Richard C [Signature] MD</i> | | | | 29c. LICENSE NUMBER
M6199 | | | |
| 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard Wm MD SHH 600 N Broadway Baltimore MD 21287 | | | | 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | |
| 32. REGISTRAR'S SIGNATURE
<i>John [Signature]</i> | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06973

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|---|---|---|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ralph THOMAS Eley | | | | 2. DATE OF DEATH
MONTH 24 DAY 19 YEAR 1995 | | | | 3. TIME OF DEATH
2:32P | | | | | |
| 4. SOCIAL SECURITY NUMBER
213-09-2079 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs., last birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 7. DATE OF BIRTH
(Month, Day, Year)
MAR. 16, 1909 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | |
| 9a. FACILITY NAME (If not institution, give street and number)
LIBERTY MEDICAL CENTER | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | | | 9c. COUNTY OF DEATH
n/a | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
3910 DORCHESTER ROAD | | | | | 10f. ZIP CODE
21207 | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 1 st College (1-4 or 5+) - | | | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
STEEL FINISHER | | | | 16b. KIND OF BUSINESS/INDUSTRY
BETHLEHEM STEEL YARD | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
RICHARD ELEY | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SARAH DARDEN ELEY | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LOTTIE MC CALLUM | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2025 E. HOFFMAN STREET, BALTIMORE, MARYLAND #13 | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MARYLAND NATIONAL CEM. 3-3 LAUREL, MARYLAND | | | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Symette K. Jones</i> | | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Aspiration Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. COPD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Hypertension, Demented | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Anil Uberoi MD</i> | | | | | | 29c. LICENSE NUMBER
D26748 | | 29d. DATE SIGNED (Month, Day, Year)
3/2/95 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ANIL UBEROI 4419 FALLS RD BALTIMORE MD 21211 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Andrew Parkell</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06974

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Minnie A. Erbe | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Mar. 5, 1995 | | 3. TIME OF DEATH
8:40 a.m. | |
| 4. SOCIAL SECURITY NUMBER
213-18-1899 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 17, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto. City, Md. | | 9c. COUNTY OF DEATH
none | |
| 10a. STATE
Maryland | | 10b. COUNTY
none | | 10c. CITY, TOWN OR LOCATION
Balto. City, Md. | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
14 E. Gittings St. | | | | 10f. ZIP CODE
21230 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th. Grade
College (1-4 or 5+) None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sales Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
G.C. Murphy & Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Cosmos Bianco | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Irene Julius | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Mary Sheckels | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 E. Gittings St. Balto. Md. 21230 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery, 3/8/95 | | 20c. LOCATION — City or Town, State
Balto. City, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
End stage chronic obstructive lung disease
Kidney Failure, pneumonia
Sepsis, Encephalopathy, Hypercalcemia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Heart Failure, Ruptured Aortic Aneurysm with By-pass, Cholecystitis, Hypertension

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | Approximate interval Between Onset and Death
3 months |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John A. [Signature]</i> | | 29c. LICENSE NUMBER
D26839 | | 29d. DATE SIGNED (Month, Day, Year)
3/5/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
NABIL BADRO, M.D. 1600 Chain Hwy Suite 102 Glen Burnie, MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. SIGNATURE OF REGISTRAR
<i>John A. [Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06975

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
MAUDE EDNA FETZER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 5, 1995 | | 3. TIME OF DEATH
10:00A.M. | |
| 4. SOCIAL SECURITY NUMBER
172-05-3081 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)
FEB 11, 1915 | |
| 8. FACILITY NAME (If not institution, give street and number)
Stella Maris | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON | | 9c. COUNTY OF DEATH
Balto | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md | | 10b. COUNTY
Balto. | | 10c. CITY, TOWN OR LOCATION
PARKVILLE | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9644 DIXON AVE | | | | 10f. ZIP CODE
21234 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sales Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Retail | |
| 17. FATHER'S NAME (First, Middle, Last)
William Reese | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude Turner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DEBRA G. BRYAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16106 Kent Rd Laurel, Md. 20707 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gdns | | 20c. LOCATION — City or Town, State
39/ks TIMONIUM, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
EVANS Chapel of Memories
8800 Harford Rd. Balto. Md. 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Kendall R Faulkner</i> | | | | 29c. LICENSE NUMBER
D25643 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 6 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06976

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edward G. Fitch | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 6, 1995 | | 3. TIME OF DEATH
3:21 A M | |
| 4. SOCIAL SECURITY NUMBER
215-10-1121 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec 14, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventis Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Gaithersburg | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10e. STREET AND NUMBER
3804 Tudor Arms Avenue | | | | 10f. ZIP CODE
21211 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Machinist Foreman | | 16b. KIND OF BUSINESS/INDUSTRY
Crown, Cork & Seal Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Edward Fitch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Esther R. Pearson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Gary Fitch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8202 Evergreen Dr., Balto., Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Woodlawn Cemetery 3/8/95 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
A. Alan Seitz, Jr. Funeral Home
3818 Roland Ave., Baltimore, Maryland 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute myocardial infarction | | | | | Approximate Interval Between Onset and Death
<24° |
| | | b. Congestive heart failure | | | | | >48° |
| | | c. Coronary artery disease | | | | | >10yrs |
| | | d. Pneumonia | | | | | >48° |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Emphysema
Renal failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
S. Sudhakar MD | | | | 29c. LICENSE NUMBER
D35792 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH-06-1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SWAROOP SUDHAKAR, 50, W. EDMONSTON DR, R, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | |

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06977

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM RUSSELL GATLING, JR. | | | | 2. DATE OF DEATH
MONTH MARCH DAY 1 YEAR 95 | | 3. TIME OF DEATH
12:05 A M | |
| 4. SOCIAL SECURITY NUMBER
216-16-6201 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
06-24-26 | |
| 9a. FACILITY NAME (If not institution, give street and number)
5307 MORAVIA ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
VA | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5307 MORAVIA RD. | | | | 10f. ZIP CODE
21206 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
FEDERAL RESERVE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM RUSSELL GATLING, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
EMMA MAE TURNER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CARRIE GATLING | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5019 TRUESDALE AVE BALTIMORE, MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GARRISON FOREST VA 3/7 | | 20c. LOCATION — City or Town, State
OWINGS MILLS, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BETTS FUNERAL HOME
1129 N. CAROLINE ST. BALTO, MD 21213 | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic prostate cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes COPD | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D33026 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
29 0. PAPA SD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 7 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>CATHERINE GRAHAM</u> Catherine Graham | | | | 2. DATE OF DEATH
MONTH <u>03</u> DAY <u>05</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>6:20 A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>194-32-5483</u> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>62</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>JAN. 16, 1933</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>CHURCH HOME HOSPITAL</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>BALTIMORE CITY</u> | | 9c. COUNTY OF DEATH
<u>n/a</u> | |
| 10a. STATE
<u>MARYLAND</u> | | | | 10b. COUNTY
<u>n/a</u> | | 10c. CITY, TOWN OR LOCATION
<u>BALTIMORE</u> | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
<u>6611 BELAIR ROAD</u> | | | | 10f. ZIP CODE
<u>21206</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>UNITED STATES</u> | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12 TH</u> College (1-4 or 5+) <u>-</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>nursing assistant</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>n/a</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>n/a</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>ELLEN FULMORE</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>BELINDA WHITE</u> | | | | 19b. MAILING ADDRESS (Street and Route Number, City or Town, State, Zip Code)
<u>1047 PLAZA CIRCLE, JOPPA, MARYLAND 21085</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>BALTIMORE CEMETERY 3-9</u> | | 20c. LOCATION — City or Town, State
<u>BALTIMORE, MARYLAND</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Bernard D. Johnson</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <u>Bilateral Pneumonia</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>End Stage Renal Disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
<u>14 days</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>James Mahmood MD</u> | | | | 29c. LICENSE NUMBER
<u>044378</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>3/5/95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>MANSON MAHMOOD 2501 KENYON RD. 58-05 BENSALEM PA 19020</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR 07 1995</u> | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06979

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CAROLINE H. WELLS-GRABILL | | | | 2. DATE OF DEATH
MONTH 03 DAY 06 YEAR 95 | | 3. TIME OF DEATH
12:09 P M | |
| 4. SOCIAL SECURITY NUMBER
214-03-1163 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH
MONTH 02 DAY 25 YEAR 07 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
MERIDIAN NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
SEVERNA PARK | |
| 9c. COUNTY OF DEATH
ANNE ARUNDEL | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION
GLEN BURNIE | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
300 4TH AVENUE S.E. | |
| 10f. ZIP CODE
21061 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SECRETERY | | 16b. KIND OF BUSINESS/INDUSTRY
SILVERSMITHS | |
| 17. FATHER'S NAME (First, Middle, Last)
CHARLES S. HARRISON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
EMMA F. BROWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
NORVA H. POPE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 MELVILLE ROAD-PASADENA, MD. 21122 | | | |
| 20. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment)
MEADOWRIDGE CEMETERY | | 20c. LOCATION — City or Town, State
3/10 ELKRIDGE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Darryl L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY
RAYMOND C. FINK FUNERAL HOME 21061
426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ventricular arrhythmia
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardiac failure
c. Senile dementia | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>V. M. [Signature]</i> | | | | 29c. LICENSE NUMBER
D-29851 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
203, E. Patapsco Ave. Baltimore MD-21225. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Shuchter-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06980

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edward John Garrity, SR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 3 1995 | | 3. TIME OF DEATH
9:08 A.M. | |
| 4. SOCIAL SECURITY NUMBER
219-12-7387 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
November 11, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Fallston General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fallston | | 9c. COUNTY OF DEATH
Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Bel Air | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
203 Yorkshire Way E | | | | 10f. ZIP CODE
21014 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
8 years | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edward Garrity | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Barnhart | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marjorie A. Webster | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 H Lockhart Circle, Forest Hill, Maryland 21050 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holy Redeemer Cem. 3/4/95 | | 20c. LOCATION — City or Town, State
Baltimore City, MD | | 20d. NAME AND ADDRESS OF FACILITY
Evans Funeral Chapel - Bel Air, 3 Newport Drive, Forest Hill, 21050 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiomyopathy

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Ischemic Coronary Artery Disease
Atherosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death
years
years
years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Bacterial Colitis
Nephrosclerosis | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Kermit P. Bonovich MD | | 29c. LICENSE NUMBER
D05593 | | 29d. DATE SIGNED (Month, Day, Year)
March 3, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Kermit Patrick Bonovich MD 754 Hickory Ave. Bel Air Md. 21014 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06981

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Victor C. Glorioso | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 5, 1995 | | 3. TIME OF DEATH
5:00 A^M | |
| 4. SOCIAL SECURITY NUMBER
218-07-0040 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
75 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
11-26-1919 | 8. BIRTHPLACE (State or Foreign Country)
Mass. | | |
| 9a. FACILITY NAME (If not institution, give street and number)
2815 Edison Highway | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2815 Edison Highway | | | | 10f. ZIP CODE
21213 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sheet Metal Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Coast Guard | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Salvatore Glorioso | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ida H. Glorioso | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2815 Edison Highway Baltimore, Md. 21213 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Greenmount Cemetery | | 20c. LOCATION — City or Town, State
3-6 Baltimore, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Charles Zannino</i> | | | | 22. NAME AND ADDRESS OF FACILITY
JOSEPH N. ZANNINO JR. FUNERAL HOME
263 S. Conkling St. Balto Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Sudden Cardiac Death | | | | | Approximate Interval Between Onset and Death
immediate |
| | | b. CORONARY Artery disease | | | | | 10 yrs |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Michael T. Rudikoff</i> | | | | 29c. LICENSE NUMBER
D18095 | | 29d. DATE SIGNED (Month, Day, Year)
3/6/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Michael T. Rudikoff 222 W. Cold Spring Lane Balto. Md. 21210 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John A. ...</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10
1/VA

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of
the methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

95 06982

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FANNIE GREITZER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MAR. 5, 1995 | | 3. TIME OF DEATH
2:48 A.M. | |
| 4. SOCIAL SECURITY NUMBER
212-48-8692 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
MAY 10, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country)
POLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
LEVINDALE NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
N/A | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
2434 W. BELVEDERE AVE. | |
| 10f. ZIP CODE
21215 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th. College (1-4 or 5+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
MOSHE BULMASH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARNA UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DR. MARC SIEGELBAUM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 IVY BROOKFARM COURT, COCKEYSVILLE, MD. 21030 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BETH JACOB CONG. 3/6/95 | | 20c. LOCATION — City or Town, State
FINKSBURG, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD., BALTO., MD. 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate interval Between Onset and Death: 5 years | | | | | | | |
| 24. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
N/A | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert B. Shocket, M.D. | |
| 29c. LICENSE NUMBER
D36356 | | | | 29d. DATE SIGNED (Month, Day, Year)
Mar. 5, 1995 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert B Shocket, M.D. 2435 W. Belvedere Ave. Baltimore MD 21215 | |
| 31. DATE FILED (Month, Day, Year)
MAR 6 7 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 95-06983 | |
|---|--|--|---|---|---|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEDENT'S NAME (First, Middle, Last)
William Vernon Hines | | | 2. DATE OF DEATH
MONTH 2 DAY 26 YEAR 95 | | 3. TIME OF DEATH
3 A M |
| 4. SOCIAL SECURITY NUMBER
216-09-2490 | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
92 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
OCT-10 1902 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number)
CARROLL COUNTY GENERAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH
WESTMINSTER | | 9c. COUNTY OF DEATH
CARROLL |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE | 10c. CITY, TOWN OR LOCATION
PARKVILLE | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 10e. STREET AND NUMBER
9000 WOOD PARK COURT | | | 10f. ZIP CODE
21234 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 6 YRS.
College (1-4 or 5+) MASTER PRINTER | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
MASTER PRINTER | | 16b. KIND OF BUSINESS/INDUSTRY
GARAMOND PRESS | |
| 17. FATHER'S NAME (First, Middle, Last)
William Marion Hines | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Guy Stevenson | | |
| 19a. INFORMANT'S NAME (Type/Print)
JAMES A. HINES | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9000 WOOD PARK COURT PARKVILLE MD 21234 | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GREEN MOUNT CEMETERY 3-1 | | 20c. LOCATION — City or Town, State
BALTIMORE MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | 22. NAME AND ADDRESS OF FACILITY
EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLI
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
ASCVD - CARDIAC ARRHYTHMIAS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY
M | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Arthur L. Rudolph</i> | | 29c. LICENSE NUMBER
D21155 | 29d. DATE SIGNED (Month, Day, Year)
2/26/95 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Arthur L. Rudolph 904 WASHINGTON RD WESTMINSTER, MD | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William E. Hasenei William Elmer Hasenei | | | | 2. DATE OF DEATH
MONTH DAY YEAR
March 5, 1995 | | 3. TIME OF DEATH
11:05 A. M | |
| 4. SOCIAL SECURITY NUMBER
219-18-6076 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
01-22-1926 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Glen Burnie | |
| 9c. COUNTY OF DEATH
A. A. County | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION
PASADENA | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
54 WISHING ROCK ROAD | |
| 10f. ZIP CODE
21122 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II & KOREAN | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) NONE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
POLICE SERGEANT | | 16b. KIND OF BUSINESS/INDUSTRY
MARYLAND TOLL FACILITY | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHN HASENEI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
AMELIA M. SCHRAM | | | |
| 19a. INFORMANT'S NAME (Type/Print)
WILLIAM LEE HASENEI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2705 WREN WAY, GLEN BURNIE, MD. 21060 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GLEN HAVEN MEMORIAL PK 3/8/95 | | 20c. LOCATION — City or Town, State
GLEN BURNIE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>R. Lee Hasenei</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Previous subendocardial myocardial infarction 2 weeks
DUE TO (OR AS A CONSEQUENCE OF):
c. atherosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate interval Between Onset and Death
1 hour
Years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic renal failure on hemodialysis; Acute stroke
SIP bladder cancer - 15 yrs ago
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
1/17 | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Bayinnah Shabazz MD | | 29c. LICENSE NUMBER
D24592 | | 29d. DATE SIGNED (Month, Day, Year)
03-06-95 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)
Bayinnah Shabazz, M.D. 1600 Crain Highway, SW, #401 Glen Burnie, Maryland 21061 | |
| 31. DATE FILED
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John A. Russell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06985

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
John Henderson | | | | 2. DATE OF DEATH
MONTH 3 - DAY 1 - YEAR 95 | | 3. TIME OF DEATH
3:00 A M | |
| 4. SOCIAL SECURITY NUMBER
220-36-3552 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5/21/1940 | |
| 8. FACILITY NAME (If not institution, give street and number)
Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
n/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Randallstown | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
#7 Korado Court Apt. 2A | | | | 10f. ZIP CODE
21244 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12)
12th | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Counselor | | 16b. KIND OF BUSINESS/INDUSTRY
Waxter Center | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Henderson, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marjorie Miller | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Edward Henderson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
619 Montford Avenue Baltimore, Md. 21205 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory 3/2/95 | | 20c. LOCATION — City or Town, State
Catonsville, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Leroy O. Dyett</i> | |
| 22. NAME AND ADDRESS OF FACILITY
LEREOY O. DYETT & SON FUNERAL HOME
4600 LIBERTY HEIGHTS AVENUE 21207 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Septic Shock
DUE TO (OR AS A CONSEQUENCE OF):
b. Disseminated Intravascular Coagulation
DUE TO (OR AS A CONSEQUENCE OF):
c. Hepato Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death
1 week
1 week
1 week | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Bautista</i> BAUTISTA (HOUSE OFFICER) | | | | 29c. LICENSE NUMBER
89233 | | 29d. DATE SIGNED (Month, Day, Year)
3-1-95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Arwinnah Bautista, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06986

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLEMENTINE ELIZABETH HUNT | | | | 2. DATE OF DEATH
MONTH MARCH DAY 2 YEAR 1995 | | 3. TIME OF DEATH
1503 P M | |
| 4. SOCIAL SECURITY NUMBER
214-24-4002 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
84 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Sept 6, 1910 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Harbor Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
n/a | |
| 10a. STATE
Maryland | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3301 Mondawmin Avenue | | | | 10f. ZIP CODE
21216 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
9th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Thomas Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maggie Rice | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Maggie J. Wilmore | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6408 Laurel Drive Baltimore, Maryland 21207 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. LOCATION — City or Town, State
Mar 8 Baltimore County, MD | | 20d. DATE
Mar 8 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Nutter Funeral Homes, Inc
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
SEPSIS
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
URINARY TRACT INFECTION DUE TO ENTEROCOCCUS | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEVERE PERIPHERAL VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
EUGENIO F VINES MD | | | | 29c. LICENSE NUMBER
AS 2441614-30 | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 2 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
EUGENIO F VINES MD 3001 SOUTH HANOVER STREET, BALTIMORE, MD, 21225. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARTIN HARRY HOCKER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 28, 1995 | | 3. TIME OF DEATH
11:15 A.M. | |
| 4. SOCIAL SECURITY NUMBER
183-03-3007 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 9, 1913 | |
| 9a. FACILITY NAME (If not institution, give street and number)
2-B Revere Ct. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2-B Revere Ct. | | | | 10f. ZIP CODE
21234 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White. | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) Superintendent | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Superintendent | | 16b. KIND OF BUSINESS/INDUSTRY
J.H. Lawrence Construction Company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Arthur Peter Hocker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margie Brosey | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Anna L. Hocker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2-B Revere Ct. Baltimore, Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gdns. 3/4/95 | | 20c. LOCATION — City or Town, State
Timonium, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUPERIOR VENA CAVA SYNDROME
b. METASTATIC LUNG CANCER
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Manuel V. Ramos M.D. | | 29c. LICENSE NUMBER
D38950 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MANUEL RAMOS, M.D., 6800 YORK RD, Baltimore, MD 21212 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1875

1875

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BESSIE HIMMELSTEIN | | | | 2. DATE OF DEATH
MONTH MAR. DAY 17 YEAR 1995 | | 3. TIME OF DEATH
7 A. | |
| 4. SOCIAL SECURITY NUMBER
578-46-1846 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year) JULY 7 1903 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
260 VISTA LANE | | 9b. CITY, TOWN OR LOCATION OF DEATH
LUSBY | |
| 9c. COUNTY OF DEATH
CALVERT | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
CALVERT | |
| 10c. CITY, TOWN OR LOCATION
LUSBY | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
260 VISTA LANE | |
| 10f. ZIP CODE
20657 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY
AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
SIMON TREPOLSKY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
IDA POLLACK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MS PHYLLIS HIMMELSTEIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
260 VISTA LA. LUSBY, MD 20657 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
OHR KNESSETH ISRAEL ANSHE SFARD 3/3/95 BALTO., MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Scott M. Cottle</i> | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
6010 REISTERTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CORONARY ARTERY DISEASE
c.
d.
Approximate interval Between Onset and Death 30 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia, diverticulosis | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Marcia Sherman MD</i> | | | | 29c. LICENSE NUMBER
044618 | | 29d. DATE SIGNED (Month, Day, Year)
3/11/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARCIA SHERMAN MD 120 Hospital Rd Prince Frederick MD 20678 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jahid Shukor-Rahall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06989

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
THOMAS E. HILLIARD | | | | 2. DATE OF DEATH
MONTH 3 DAY 03 YEAR 95 | | 3. TIME OF DEATH
1250P | |
| 4. SOCIAL SECURITY NUMBER
241-18-4046 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 18, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number)
Northwest Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Randallstown | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
Maryland | | 10b. COUNTY
Carroll County | |
| 10c. CITY, TOWN OR LOCATION
Eldersburg | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
6211 E. Hemlock Drive | |
| 10f. ZIP CODE
21784 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Routing Clerk | | 15b. KIND OF BUSINESS/INDUSTRY
Baltimore Gas & Electric | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas E. Hilliard, Sr. | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
SaVannah York | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Anne C. Hilliard | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6211 E. Hemlock Drive Eldersburg, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lake View Mem. Park 3/7/95 | | 20c. LOCATION — City or Town, State
Sykesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
William D. Haight | | | | 22. NAME AND ADDRESS OF FACILITY
HAIGHT FUNERAL HOME (P.O. Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. CHRONIC OBSTRUCTIVE LUNG DISEASE
b. SEPSIS
c. CARDIO MYOPATHY
d. MYOCARDIAL INFARCTION | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | | | | |
| 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
R. DELESTRE MD | | | | | | | |
| 29c. LICENSE NUMBER
227157 | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
R. DELESTRE NORTHWEST HOSPITAL CENTER | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 7 1995 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/17/95 t.t.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MICHAEL G. HENEHAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB. 27 1995 | | 3. TIME OF DEATH
8:21 PM | |
| 4. SOCIAL SECURITY NUMBER
213 80 5368 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
32 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 31, 1962 | |
| 9a. FACILITY NAME (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
GLEN BURNIE | | 9c. COUNTY OF DEATH
Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Pasadena | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STREET AND NUMBER
243 Arundel Road | | | | 10f. ZIP CODE
21122 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Demolition | | 16b. KIND OF BUSINESS/INDUSTRY
Self Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edward P. Henehan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Alice Lukaitis | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Alice Henehan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
243 Arundel Road Pasadena, Maryland 21122 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 3/2 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George J. Gonce</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COMBINED NARCOTIC & ALCOHOL INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
FOUND 2-27-95 | | 28b. TIME OF INJURY
UNKNOWN | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED
UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
FOUND AT HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
243 ARUNDEL RD. PASADENA, MD. | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John W. Locke MD</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 03, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John W. Locke, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 06 1995 | | 32. REGISTRAR'S SIGNATURE
<i>John W. Locke</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RANDOLPH | | | | 2. DATE OF DEATH
MONTH MARCH DAY 2 YEAR 1995 | | | | 3. TIME OF DEATH
7:52 A M | | | |
| 4. SOCIAL SECURITY NUMBER
213-54-0731 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
44 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
SEPT 18, 1950 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
1006 MOSHER STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | | | 9c. COUNTY OF DEATH
n/a | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1006 MOSHER STREET | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 TH
College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
GEORGE JOSEPH SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CECELIA DIXON | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CECELIA JOSEPH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1548 WOODYEAR STREET, BALTIMORE, MARYLAND 21217 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | DATE
3-7 | | 20c. LOCATION — City or Town, State
LANSDOWNE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Bernard & Johnson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
a. _____
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEIZURE DISORDER | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | INQUIRY | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Donald G. Wright MD</i> | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 7, 1995 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONALD G. WRIGHT M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 7 1995 | | | | | | | | | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lillie M. Jones | | | | 2. DATE OF DEATH
MONTH 03 DAY 01 YEAR 95 | | 3. TIME OF DEATH
2:55 PM | |
| 4. SOCIAL SECURITY NUMBER
212-48-2519 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV. 4, 1946 | |
| 9a. FACILITY NAME (If not institution, give street and number)
UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1514 HOLBROOK STREET | | | | 10f. ZIP CODE
21202 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
HIGHSCHOOL | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
MAINTENANCE | | 16b. KIND OF BUSINESS/INDUSTRY
BROADWAY SERVICES | |
| 17. FATHER'S NAME (First, Middle, Last)
JOHN H. LOYD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
LILLIE MAE LOYD | | | |
| 19a. INFORMANT'S NAME (Type/Print)
PATRICIA TIMMONS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6S. ARLINGTON AVENUE, BALTIMORE, MD 21223 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. LOCATION — City or Town, State
3-8 LANSDOWNE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Lee V. Bolland | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure

Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Right sided intracranial hemorrhage

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Chuan J. J. J. | | | | 29c. LICENSE NUMBER
07292 | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Joseph M. Yorkell 225. Greenest Baltimore 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CATHERINE B. JOSEPH | | | | 2. DATE OF DEATH
MONTH DAY YEAR
MARCH 04 1995 | | 3. TIME OF DEATH
HOURS MIN. SEC.
7:21 AM | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS
2 1 1 | | 7. DATE OF BIRTH (Month, Day, Year)
JAN 3, 1995 | |
| 9a. FACILITY NAME (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
RANDALLSTOWN | | 9c. COUNTY OF DEATH
BALTIMORE | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTIMORE COUNTY | | 10c. CITY, TOWN OR LOCATION
RANDALLSTOWN | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3936 TIVERTON ROAD | | | | 10f. ZIP CODE
21133 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
N/A | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
RONDELL C. JOSEPH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CAROL FRANCIS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CAROL FRANCIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3936 TIVERTON ROAD BALTIMORE, Maryland 21133 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
KING MEM. PK 3-7-95 | | 20c. LOCATION — City or Town, State
RANDALLSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Calvin L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY
GARY P. MARCH F.H. 270 FREDHILTON PASS BALTIMORE, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SUDDEN INFANT DEATH SYNDROME
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thodore M. King</i> | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
MARCH 05, 1995 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THEODORE M. KING 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
<i>Jane A. Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edna Beaty Johnson | | | | | | 2. DATE OF DEATH
MONTH 3 DAY 1 YEAR 95 | | 3. TIME OF DEATH
5:25 P M | | | |
| 4. SOCIAL SECURITY NUMBER
228-18-6618 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
11-02-1914 | | 6. BIRTHPLACE (State or Foreign Country)
VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number)
PLEASANT LIVING NURSING HOME | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
EDGEWATER | | | 9c. COUNTY OF DEATH
ANNE ARUNDEL | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | | | 10c. CITY, TOWN OR LOCATION
GLEN BURNIE | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
490 NORVELLE COURT | | | | | | 10f. ZIP CODE
21061 | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian,
Black, White, etc.
Specify:
WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed) | | | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | | | 18b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (8-12)
8 | | | | College (1-4 or 5+)
N/A | | | | SALES | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WESLEY BEATY | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARY ELLA POTTER | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ANNA LEE ORD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
490 NORVELLE COURT, GLEN BURNIE, MD. 21061 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
GLEN HAVEN MEMORIAL PK. 3/4/95 | | | | 20c. LOCATION — City or Town, State
GLEN BURNIE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
SINGLETON FUNERAL HOME
SECOND AVE., S.W. GLEN BURNIE, MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lower Lobe Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Dementia
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death
1 day
5 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

Wayne D. Bierbaum | | | | | | 29c. LICENSE NUMBER
D38563 | | | 29d. DATE SIGNED (Month, Day, Year)
3/1/95 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Wayne D. Bierbaum 134 Owensville Rd West River MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR - 7 1995 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Mary A. Jordan</i> | | | | 2. DATE OF DEATH
MONTH <i>2</i> DAY <i>28</i> YEAR <i>95</i> | | 3. TIME OF DEATH
<i>11:50 PM</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>215-82-1254</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>78 YRS.</i> | | 7. DATE OF BIRTH (Month, Day, Year)
<i>06-16-16</i> | |
| 8a. FACILITY NAME (If not institution, give street and number)
<i>3804 Hillsdale Avenue</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
<i>BALTIMORE CITY</i> | | 8c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
<i>MARYLAND</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
<i>BALTIMORE CITY</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>5322 Beaufort Avenue</i> | | | | 10f. ZIP CODE
<i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th Grade</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>HOUSEWIFE</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>N/A</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>ISACC CAREY</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>ELIZABETH CAREY</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Helen Jordan</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5376 Smooth Meadow Way Columbia, Maryland 21044</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>King Memorial Park</i> | | 20c. LOCATION — City or Town, State
<i>Woodlawn, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>WILLIAM C. BROWN COMMUNITY F/H
1206 W. North Avenue</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>Portia conium</i>
<i>1/8 CVA</i> | | | | | | | Approximate Interval Between Onset and Death
<i>2-3 yrs</i>
<i>2-3 yrs</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>R. Traynor MD</i> | | | | 29c. LICENSE NUMBER
<i>D-20158</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>03-01-95</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06996

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Stanley A. Jaeger</u> | | | | 2. DATE OF DEATH
MONTH <u>3</u> DAY <u>6</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>8:45 A</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>220-12-4523</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>74</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>10/20/20</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Northwest Hospital Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Randallstown</u> | | 9c. COUNTY OF DEATH
<u>Baltimore County</u> | |
| 10a. STATE
<u>Maryland</u> | | | | 10b. COUNTY
<u>Carroll County</u> | | 10c. CITY, TOWN OR LOCATION
<u>Sykesville</u> | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
<u>1720 Arrington Road</u> | | | | 10f. ZIP CODE
<u>21784</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>None</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>None</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Frederick C. Jaeger</u> | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Lottie B. Hobbs</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Mr. Raymond Jaeger (Brother)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>10519 Marriottsville Road Randallstown, MD 21133</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Lake View Mem. Park</u> <u>3/8/95</u> | | 20c. LOCATION — City or Town, State
<u>Sykesville, MD</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Brian D. Haight</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>HAIGHT FUNERAL HOME (P.O. Box 195)
Sykesville, MD 21784 (410)-795-1400</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <u>Malignant melanoma</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u></u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u></u>
DUE TO (OR AS A CONSEQUENCE OF):
d. <u></u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death
<u>2-3</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u></u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Allen J. Chiriacus M.D.</u> | | | | 29c. LICENSE NUMBER
<u>029085</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>3-6-95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Allen J. Chiriacus 5310 Old Court Road 21133</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR - 7 1995</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John M. ...</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>George Clifford Johnson</u> | | | | 2. DATE OF DEATH
MONTH <u>MAR</u> DAY <u>3</u> YEAR <u>95</u> | | 3. TIME OF DEATH
<u>12:10 A M</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>232-01-8666</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>74</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>01/24/1921</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Johns Hopkins Bayview Medical Ctr.</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Baltimore City</u> | | 9c. COUNTY OF DEATH
<u>N/A</u> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION
<u>Dundalk</u> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>7104 Martell Avenue</u> | | | | 10f. ZIP CODE
<u>21222</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>3 Years</u>
College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Mechanic</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Tractor Trailer</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Manuel Headge Johnson</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Sarah May Hartman</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Selena Nadolny</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>7104 Martell Avenue Dundalk, MD 21222</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION
(Specify cemetery, crematory, etc.)
<u>Oak Lawn Cemetery 3/4/95</u> | | 20c. DATE
<u>3/4/95</u> | | 20d. LOCATION — City or Town, State
<u>Baltimore, MD</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Johnny L. Gibbs</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Duda-Ruck Funeral Home of Dundalk, Inc.</u>
<u>7922 Wise Ave. Dundalk, MD 21222</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PNEUMONIA</u>
Approximate Interval Between Onset and Death <u>14 DAYS</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<u>RENAL FAILURE</u> <u>14 DAYS</u>
<u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u> <u>21 DAYS</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Walter Schaefer M.D.</u> | | | | 29c. LICENSE NUMBER
<u>B1211</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>3-3-95</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>LUKE SCHOENIGER 600 N. WOLFE ST BALTIMORE MD 21205</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>MAR 07 1995</u> | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 06998

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
THOMAS LIGHTNER SR. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 25, 1995 | | 3. TIME OF DEATH
2:00 pm | |
| 4. SOCIAL SECURITY NUMBER
705-10-9518 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 26, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country)
S. CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number)
1525 N. BOND STREET | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | |
| 9c. COUNTY OF DEATH
n/a | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
n/a | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1525 N. BOND STREET | |
| 10f. ZIP CODE
21213 | | | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES <input checked="" type="checkbox"/> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 TH College (1-4 or 5+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER - part METAL | | 16b. KIND OF BUSINESS/INDUSTRY
FLEMMINGTON & FOUNTAIN | |
| 17. FATHER'S NAME (First, Middle, Last)
BENJAMIN LIGHTNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
JULIA WILEY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
THOMAS LIGHTNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2231 HOMEWOOD AVENUE, BALTIMORE, MARYLAND#13 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | DATE
3-2 | | 20c. LOCATION — City or Town, State
BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Bernard D Johnson | | | | 22. NAME AND ADDRESS OF FACILITY
WM. C. MARCH FH.-1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
30 Sec | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes, Lower extremity edema | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MP | | | | 29c. LICENSE NUMBER
64761 | | 29d. DATE SIGNED (Month, Day, Year)
3/3/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Power JH A Newbold street Balt MD 21207 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
IPHAGENIA IPHAGENIA HINTON LONG | | | | 2. DATE OF DEATH
MONTH DAY YEAR
FEB 23, 95 | | 3. TIME OF DEATH
3:15 P.M. | |
| 4. SOCIAL SECURITY NUMBER
213-26-9139 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11 13 - 29 | |
| 9a. FACILITY NAME (If not institution, give street and number)
2247 CECIL AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
MD | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
BALT | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
2247 CECIL AVE | | | | 10f. ZIP CODE
21218 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) (12) College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
FOOD SERVICE MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY
DINER | | | |
| 17. FATHER'S NAME (First, Middle, Last)
AXUM HINTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
PEARL EVANS | | | |
| 19a. INFORMANT'S NAME (Type/Print)
IRENE COOPER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2304 TIMBER DR RALIEGH NC 27604 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BAND ST. CHRISTIAN CH. CEM 21 | | 20c. LOCATION — City or Town, State
GARNER, N.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Patricia Bett | | | | 22. NAME AND ADDRESS OF FACILITY
BETTS FUNERAL HOME
1129 N. CAROLINE ST. BALTO, MD 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Small Cell Carcinoma of Lung
DUE TO (OR AS A CONSEQUENCE OF):
a.
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
2 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. Douglas Kizzo MD | | | | 29c. LICENSE NUMBER
D44529 | | 29d. DATE SIGNED (Month, Day, Year)
2/24/95 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. Douglas Kizzo MD, 600 N. Wolfe St., Baltimore MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAR 07 1995 | | | | 32. REGISTRAR'S SIGNATURE
John A. H. H. H. | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 07000

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Julia M. Luecking</i> | | | | 2. DATE OF DEATH
MONTH <i>March</i> DAY <i>7</i> YEAR <i>1995</i> | | 3. TIME OF DEATH
<i>3:10 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>215-22-0562</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
<i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Aug. 6, 1906</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Frederick Villa Nursing Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH
<i>Baltimore, Maryland</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
<i>Md.</i> | | 10b. COUNTY
<i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION
<i>Catonsville</i> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>1504 Idlewilde Avenue</i> | | | | 10f. ZIP CODE
<i>21228</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>white</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11</i>
College (1-4 or 5+) <i>College</i> | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Housewife</i> | | 18b. KIND OF BUSINESS/INDUSTRY
<i>Own Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>John Flanigan</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Dehlia Tierney</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Joseph Luecking, Jr.</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>102 Fairfield Drive, Catonsville, Md. 21228</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>New Cathedral Cemetery 3/10</i> | | 20c. LOCATION — City or Town, State
<i>Baltimore, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Peter S. Galt</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Sterling Ashton Funeral Home
736 Edmondson Avenue, Catonsville, Md. 21228</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. <i>Aspiration pneumonia</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Status epilepticus</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL:
<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one)
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
<i>D28236</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>March 7, 1995</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Dorian S St Martin M.D. 541 Old Frederick Rd 21229</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>MAR 07 1995</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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